

NEW JERSEY

**STATE
HEALTH BENEFITS
PROGRAM**

TRADITIONAL PLAN

***MEMBER
HANDBOOK***

FOR EMPLOYEES AND RETIREES

**Department of the Treasury
Division of Pensions and Benefits**

**Administered by
Horizon Blue Cross Blue Shield of New Jersey**

January 2005

The following additions and/or deletions occurred to the
Traditional Plan Member Handbook
Effective April 1, 2006

Additions are shown thus (member); deletions are shown thus (~~member~~)

● Page 7

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, eligible same-sex domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. It is required that they enroll in both Medicare Parts A and B prior to retirement so that coverage will be effective at the time of retirement. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD) you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work. For more information, see "Medicare Coverage" in the "Retiree Eligibility" section beginning on page 10.

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Eligibility for membership in the SHBP for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college — or certain disability retirees, see below); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is *enrolled* in the SHBP immediately preceding the effective date of your retirement.

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for health coverage under the Retired Group of the SHBP. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

Employees whose coverage is terminated prior to retirement **but who are later approved for a disability retirement** will be eligible for coverage under the Retired Group of the SHBP beginning on the employee's retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

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~~Note: If you continue group coverage through COBRA (see page 13 for an explanation of COBRA) or as a dependent under other coverage through a public employer until your retirement becomes effective, you will be eligible for retired coverage under the SHBP.~~

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Plan Benefits

Employee Prescription Drug Plan benefits are available through a participating **retail pharmacy** or through the Caremark **mail order** and **specialty pharmacy services**.

- **Retail Pharmacy** services require a copayment for each 30-day supply. Employee Prescription Drug Plan participants may obtain up to a 90-day supply of prescription drugs at participating retail pharmacies. You are required to pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply.
- **Mail Order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment.
- **Specialty Pharmacy Services**, effective February 15, 2006, are provided through Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP's prescription drug plans. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact CaremarkConnect at 1-800-237-2767. When calling, identify yourself as a State Health Benefits Program member. Caremark will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

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~~Beginning in January of 2005, A mail order service is also available through the Employee Prescription Drug Reimbursement Plan for the Traditional Plan for active employees (including COBRA participants) who do not have a separate prescription drug plan through their employer. The mail order service is administered by Horizon Blue Cross Blue Shield of New Jersey through the mail service pharmacy owned and operated by Caremark. Members may order maintenance prescriptions by mail or online from *caremark.com* , the mail service pharmacy owned and operated by Caremark.~~

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services” (listed above in this addendum).

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RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in the Traditional Plan have access to a separate Retiree Prescription Drug Plan that includes retail pharmacy, ~~and mail order, and specialty pharmacy services.~~ The plan is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark, and features a three-tiered design. Based on the design adopted at the time the plan was implemented, effective January 1, ~~2005~~ 2006, copayment amounts for a 30-day supply are set at ~~\$7~~ \$8 for **generic** drugs (Tier I), ~~\$14~~ \$16 for **preferred brand name** drugs (Tier II), and ~~\$29~~ \$33 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are ~~\$7~~ \$8 for **generic** drugs, ~~\$24~~ \$25 for **preferred brand name** drugs, and ~~\$36~~ \$41 for **all other brand name** drugs.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services” (on page 2 of this addendum).

Effective January 1, ~~2005~~ 2006, there is a ~~\$552~~ \$1,000 annual maximum in prescription drug copayments per person. Once a person has paid ~~\$552~~ \$1,000 in copayments, that person is no longer required to pay any prescription drug copayments for the remainder of the calendar year.

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Obstetrical Care Benefits - Inpatient

Hospital and delivery charges related to the mother's obstetrical care and the newborn child's and mother's initial stay in the hospital are covered. The plan will provide coverage for a minimum of 48 hours of inpatient care for the mother and newly born child following a vaginal delivery and up to 96 hours following a cesarean section. If a doctor orders care beyond the 48/96 hours, medical records will be required to determine continued medical need.

In some instances, the plan will also pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- The mother must be enrolled as a dependent;
- The mother resides with the member and must be substantially dependent on the member for support and maintenance; and
- The mother is under the age of 23 and unmarried.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if he or she obtains legal custody of the child. ~~The mother may apply for COBRA coverage for the newborn.~~

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Mental Health Maximums

The Traditional Plan also contains a unique automatic restoration provision, which can restore benefits issued for non-biologically-based mental illnesses. This special restoration of benefits is in addition to the restoration provision for the overall plan lifetime benefit maximum. This provision is applicable in the calendar year immediately following the initial calendar year in which benefits are paid for mental illness. The patient must be a covered person at the beginning of the year the restoration begins. The maximum that may be restored in a calendar year is **\$2,000**. The amount restored will be the lesser of **\$2,000** or the amount that will bring the total lifetime benefits to **\$20,000**. A maximum restoration of **\$20,000** is available for the lifetime of the patient. Services for mental and nervous disorders, that are non-biologically-based, have a **\$10,000 annual maximum/\$20,000 lifetime maximum** with a **\$2,000** automatic restoration provision for all services.

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Maintenance Care — ~~Care given to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function.~~ Maintenance care is care that when provided **does not** substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Maintenance care services, even those that are considered to be medically needed, are not eligible for coverage under the Traditional Plan.

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INTRODUCTION

The State Health Benefits Program (SHBP) was originally established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program. The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

The Traditional Plan is an indemnity plan that provides reimbursement of expenses for treatment of illness and injury. The Traditional Plan is self-funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members.

The Traditional Plan is administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). This plan allows you to use any eligible licensed provider, as defined by the plan, for covered medical services. The plan pays only for the diagnosis and treatment of illness or injury. It does not pay for preventive treatment such as immunizations, physical exams, screening tests, and well-care visits to doctors.

An online version of this handbook containing current updates is available for viewing over the Internet at: www.state.nj.us/treasury/pensions/shbp.htm. Be sure to check the Division of Pensions and Benefits Internet home page at: www.state.nj.us/treasury/pensions for SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

Every effort has been made to ensure the accuracy of the *Traditional Plan Member Handbook*, which describes the benefits provided in the contract with Horizon BCBSNJ. However, State law and the New Jersey Administrative Code govern the SHBP. **If there are discrepancies between the information presented in this handbook, and the law, regulations, or contract, the latter will govern.**

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: pensions.nj@treas.state.nj.us. Refer to page 84 for information on contacting the SHBP and its related health services.



SPECIAL PLAN PROVISIONS UNDER THE SHBP

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans which cover mastectomies, must provide coverage for breast reconstruction surgery to produce a symmetrical appearance, prostheses, and treatment of any physical complications.

AUTOMOBILE-RELATED INJURIES

The SHBP will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your SHBP plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your health plan, then the SHBP will automatically be primary to your PIP policy. If you elect your SHBP plan as primary, this election may affect each of your family members differently.

When the SHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the SHBP health plan you have chosen. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your SHBP plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

If your SHBP plan is secondary to the PIP policy, when applicable, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your SHBP plan, after application of any deductibles and coinsurance; or
- The actual benefits that would have been payable had your SHBP plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your plan's handbook and your PIP policy to assist you in making this decision.

Please note: There is no coordination of benefits for prescription drug expenses.

WORK-RELATED INJURY OR DISEASE

Work-related injuries or disease are not covered under the SHBP. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not your injuries are covered by a Workers' Compensation policy.

- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the State Health Benefits Program, you may be subject to prosecution for insurance fraud.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal governmental plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Mental Health Parity Act Requirements

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services for calendar year 2005. As a result, maximum annual and lifetime dollar limits apply to mental health benefits under the Traditional Plan, except for *biologically-based* mental illness. Maximum annual and lifetime dollar limits for mental health benefits are outlined for the Traditional Plan in this handbook and are also described in the *SHBP Comparison Summary Chart* (see page 85 for information on how to obtain this publication).

All SHBP health plans meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity would require that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. This includes any prior group plan coverage that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your SHBP group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The State Health Benefits Program makes every effort to safeguard the health information of its members and complies with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health. See page 80 for the State Health Benefits Program's *Notice of Privacy Practices*.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a policy, New Jersey residents who are not Medicare eligible, should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at www.njdobi.org

If you are Medicare eligible you may qualify for a Medigap policy through the New Jersey Department of Health and Senior Services — State Health Insurance Program (SHIP). For more information, contact SHIP at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to a direct payment policy.

MEDICAL PLAN EXTENSION OF BENEFITS

If you or a dependent are totally disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this specific condition or illness. If you feel that you may qualify for an extension of benefits please contact Horizon BCBSNJ for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension under any SHBP plan will be for the time you remain totally disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which your coverage ends. During an extension there will be no automatic restoration of part or all of a life-time benefit maximum.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of coverage for dependents.

STATE HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

STATE EMPLOYEES

To be eligible for Traditional Plan State employee coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time normally requires 35 hours per week.

The following categories of employees are not eligible for coverage under the Traditional Plan.

State Part-Time Employees — Part-time employees of the State and part-time faculty at institutions of higher education that participate in the SHBP are eligible for coverage under NJ PLUS and the Employee Prescription Drug Plan if they are members of a State-administered pension system. The employee or faculty member must pay the full cost of the coverage. Part-time employees will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*, for more information.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) will be eligible for NJ PLUS and/or the Employee Prescription Drug Plan. Intermittent employees who maintain 750 hours of work per year continue to qualify for health benefits in subsequent years. See Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*, for more information.

New Jersey National Guard — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll in NJ PLUS and the Employee Prescription Drug Plan at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and for notifying the Division of Pensions and Benefits of members who are eligible.

State Employees Enrolled On or After July 1, 2003 — Certain State employees who enroll in the SHBP on or after July 1, 2003 are not eligible for coverage under the Traditional Plan. This group includes State employees as determined by union contract and all non-aligned State employees as provided under Chapter 119, P.L. 2003. See your human resources representative for information about your union affiliation.

LOCAL EMPLOYEES

To be eligible for Traditional Plan local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

The following categories of employees are not eligible for coverage under the Traditional Plan.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SHBP is eligible for coverage under NJ PLUS — and if provided by the employer the Employee Prescription Drug Plan — if they are members of a State-administered pension system. The faculty member must pay the full cost of the coverage. Part-time faculty members will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*, for more information.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse or eligible same-sex domestic partner (as defined below) and/or your eligible unmarried children (as defined below).

Spouse — This is a member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate is required for enrollment.

Domestic Partner — This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships) is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for details).

Children — This includes your unmarried children under age 23 who live with you in a regular parent-child relationship, your children who are away at school, as well as divorced children living at home provided that they are dependent upon you for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children — *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases. If a Qualified Medical Child Support Order (QMCSO) is issued for your child, the health plan of the parent named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a *NJ State Health Benefits Program Application* submitted electing coverage for the child within 60 days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, enters into a domestic partnership, moves out of the household, turns age 23, or is no longer dependent on you for support and maintenance. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the COBRA section on page 13 for continuation of coverage provisions).

Dependent Children with Disabilities — If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage. To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

RETIREE ELIGIBILITY

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with 25 years or more of service credit in one or more State or locally-administered retirement system or who retire on a disability retirement, even if their employer did not cover its employees under the SHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement system (see *Aggregate of Service Credit* on page 9).
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with less than 25 years of service credit from an employer that participates in the SHBP.
- Full-time members of the TPAF and PERS who retire from a board of education, vocational/ technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B.
- Participants in the Alternate Benefit Program (ABP) who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- Certain local policemen or firemen with 25 years or more of service credit in the pension fund or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330*, for more information.
- Surviving spouses, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

Eligibility for membership in the SHBP for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and

2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP immediately preceding the effective date of your retirement.

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for health coverage under the Retired Group of the SHBP. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

Note: If you continue group coverage through COBRA (see page 13 for an explanation of COBRA) — or as a dependent under other coverage through a public employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP.

Aggregate of Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP. A full-time employee of a local government who has 25 years or more of service credit whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP. Effective August 15, 2001, instead of having to meet the 25-year service credit requirement from a single State or locally-administered retirement system, a retiree under the SHBP may receive this benefit **if** the 25 years of service credit is from one or more State or locally-administered retirement systems **and** the time credited is nonconcurrent.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 6) except for the Medicare requirements (see page 10).

Enrolling in the Retired Group of the SHBP

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in the SHBP's Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of SHBP coverage or delay of eligibility.

Additional restrictions and/or requirements may apply when enrolling in the Retired Group of the SHBP. Be sure to carefully read the *Retiree Enrollment* section of the *SHBP Summary Program Description* (see page 85 for information on how to obtain this publication).

MEDICARE COVERAGE

IMPORTANT: A Retired Group member and/or dependent(s) who are eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the SHBP.

IMPORTANT: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP for the provider's services.

A Member May be Eligible for Medicare for the Following Reasons:

- ***Medicare Eligibility by Reason of Age***

This applies to a member who is the retiree or covered spouse/same-sex domestic partner and is at least 65 years of age.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reason of Disability***

This applies to a member or dependent who is under age 65.

A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The retired group health plan is the secondary plan to Medicare when the member is the subscriber, is under age 65, and is retired, or when the dependent is covered under Medicare and not covered under any active employer group plan.

- ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse or domestic partner).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules listed above, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, **the group health plan is primary.**

Coordination of benefits period

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage.** Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary.**

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** to 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer.** There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."

- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to the SHBP Traditional Plan for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits*, you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form of your SHBP plan.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Retirees With Medicare Who Move Outside the United States

Medicare does not cover services outside the United States. For SHBP members who reside outside the United States, the Traditional Plan covers services as if the plan were primary.

Members who reside outside the United States must still maintain their Medicare coverage (Parts A and B) in order to be covered under the SHBP.

Members who reside outside the United States, even if they reside in a country with socialized medicine, should consider that if they travel outside their country of residence they will still need coverage. In order to have SHBP coverage at any time in the future, the member must stay enrolled in the SHBP, since once a member terminates coverage they will not normally be reinstated.

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods (see *Duration of COBRA Coverage*, on page 14), and the member must pay the full cost of the coverage plus an administrative fee.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP health plan and, if offered by your employer, SHBP prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the employee/retiree.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of same-sex domestic partnership (makes spouse or same-sex domestic partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, marriage, or dependent partnership.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Proof of Social Security Administration determination must be submitted within 60 days of the award or within 60 days of COBRA enrollment. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a same-sex domestic partnership**, or he or she becomes ineligible for continued group coverage because of **marriage, entering into a domestic partnership, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage**.

If a second qualifying event — such as a divorce — occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the SHBP within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits

Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a same-sex domestic partnership, or your death has occurred or that your child has married, entered into a domestic partnership, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;

- File a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a “qualified beneficiary” under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP; or
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

TRADITIONAL PLAN BENEFITS

USING THIS HANDBOOK

How to Determine Available Benefits

The Traditional Plan provides benefits in three distinct categories: **Basic Benefits**, **Extended Basic Benefits**, and **Major Medical Benefits**. The medical services you receive may fall into any or all of these three categories. Therefore, you should review all three categories of benefit descriptions in this handbook to determine which benefits are covered for a specific service. For example, when using the hospital emergency room, covered expenses would be found under the *Basic Benefits*, *Extended Basic Benefits*, and *Major Medical Benefits* sections of this handbook.

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections.

Even though a service or supply may *not* be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

GENERAL CONDITIONS OF THE PLAN

The plan will pay only for **eligible services** or **supplies**, which:

- Are medically needed at the appropriate level of care (see below) for the medical condition (When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon BCBSNJ.);
- Are listed in the *Eligible Services and Supplies* sections of this handbook;
- Are ordered by a doctor (as defined by the plan) for treatment of illness or injury;
- Were provided while you or your eligible family members were covered by the plan;
- Are not specifically excluded (listed in the *Charges Not Covered by the Plan* section beginning on page 48).

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply as recommended by the treating physician is determined by Horizon BCBSNJ and must meet **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

- That it is the most appropriate level of service or supply considering the potential benefits and harms to the patient.
- It is known to be effective in improving health outcomes (for new interventions, effectiveness is determined by scientific evidence; then, if necessary, by professional standards; then, if necessary, by expert opinion).
- It is furnished by an eligible provider with appropriate training, experience, staff, and facilities to furnish this particular service or supply.

When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon BCBSNJ.

Reasonable and Customary Allowances

The plan covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

Experimental or Investigational Treatments

The plan does not cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be considered experimental or investigational if the claims administrator determines that one or more of the following is true.

- The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II, and III clinical trials, with the exception of approved cancer trials.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The claims administrator will determine this based on:
 - Published reports in authoritative medical literature; and
 - Regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
- It is a drug, device, or other supply that is subject to FDA approval but:
 - Does not have FDA approval for sale and use in the United States (that is, for introduction into and distribution in interstate commerce); or
 - Has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
 - Has FDA approval, but is being used for an indication or at a dosage that is not an acceptable **off-label use**. Horizon BCBSNJ will determine if a

certain use is an accepted off-label use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Dispensing Information; or

- Is an FDA-regulated product, service, supply, or drug under any FDA program other than FDA approval for introduction and distribution into interstate commerce.
- The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
- The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such a consent.
- Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
- The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.

Educational or Developmental Services or Supplies, or Educational Testing

The Traditional Plan does not cover services or supplies that are rendered with the primary purpose being to provide the person with any of the following:

- Training in the activities of daily living. This does not include services directly related to treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.
- Instruction in scholastic skills such as reading and writing.
- Preparation for an occupation.
- Treatment for learning disabilities.
- Services rendered at Alternative Educational Facilities.
- To promote development beyond any level of function previously demonstrated.

In the case of a hospital stay, the stay, services, and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient.

Predetermination of Benefits

A predetermination for any service may be obtained *in writing* in advance of services being rendered. The written request will need to include the provider's name, address, and phone number, the diagnosis, a description of the services to be rendered, and the anticipated charges. Telephone contact with Horizon BCBSNJ or the Division of Pensions and Benefits

about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect. A predetermination is valid for one year from the date issued.

Custodial, Maintenance, and Supportive Care

The Traditional Plan does not provide coverage for services that are determined to be for custodial, maintenance, and/or supportive care. Custodial care relates to services that do not require the skill level of a nurse to perform. These services include, but are not limited to, assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Maintenance care is care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Supportive care is treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains.

Regardless of whether they are medically necessary, custodial, maintenance, and/or supportive care are ineligible for reimbursement under the Traditional Plan.

Discounted Providers

Traditional Plan members and their covered dependents are eligible to take advantage of increased savings by using a special Blue Cross Blue Shield (BCBS) program. In this program, participating providers contract with BCBS plans throughout the country. When you use a participating provider, the Traditional Plan pays the provider. You pay the provider your 20 percent coinsurance based on a contracted fee and applicable deductible amounts, thereby reducing your out-of-pocket cost. Participating providers submit all claims directly to the BCBS plan, eliminating the necessity of claim forms.

To find out if your provider participates in the program, or to identify participating providers, call 1-800-414-SHBP (7427) or contact the local BCBS plan in the area where you reside.

PRESCRIPTION DRUG BENEFITS

EMPLOYEE PRESCRIPTION DRUG PLAN

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate prescription drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Employee Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through Caremark.

Plan Benefits

Employee Prescription Drug Plan benefits are available through a participating **retail pharmacy** or through the Caremark **mail order service**.

- **Retail pharmacy** services require a copayment for each 30-day supply. Employee Prescription Drug Plan participants may obtain up to a 90-day supply of prescription drugs at participating retail pharmacies. You are required to pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply
- **Mail order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment.

For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the *Employee Prescription Drug Plan Member Handbook* which is available from your employer, from the Division of Pensions and Benefits, or at the SHBP home page at: www.state.nj.us/treasury/pensions/shbp.htm

PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH SHBP HEALTH PLANS

The State Health Benefits Commission requires that all participating employees and retirees have access to prescription drug coverage.

- **If you are employed by a county, municipality, board of education, or other local public employer that does not provide a separate prescription drug plan**, your SHBP health plan will include prescription drug benefits.
- **If you are eligible for prescription drug coverage through a separate drug plan provided by your employer**, your SHBP medical plan will not include prescription drug coverage and any prescription drug copayments from other group plans will not be reimbursed through the Traditional Plan, NJ PLUS, or any SHBP HMO.

Employee Prescription Drug Reimbursement Plan for Traditional Plan Members

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Employee Prescription Drug Reimbursement Plan for the Traditional Plan. The Employee Prescription Drug Reimbursement Plan is accepted at most pharmacies nationwide. These pharmacies have agreed to provide prescription drugs at a discounted price to plan members. When you use a participating pharmacy, most claims can be submitted electronically to the plan for consideration, and you will be reimbursed the applicable percentage of the discounted price after satisfying your deductible.

After your Traditional Plan out-of-pocket maximum has been reached (see *Coinurance* on page 36), you will be reimbursed 100 percent of the eligible pharmacy price under the Employee Prescription Drug Reimbursement Plan.

Beginning in January of 2005, a mail order service is also available through the Employee Prescription Drug Reimbursement Plan for the Traditional Plan for active employees (including COBRA participants) who do not have a separate prescription drug plan through their employer. The mail order service is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark. Members may order maintenance prescriptions by mail or online from *caremark.com*, the mail service pharmacy owned and operated by Caremark.

Using a pharmacy that does not participate in the plan may result in higher out-of-pocket costs. If you have a prescription filled at a non-participating pharmacy or forget to present your Employee Prescription Drug Reimbursement Plan identification card, you will need to submit a completed claim for reimbursement.

Some prescription drugs are covered by the Employee Prescription Drug Reimbursement Plan only in certain quantities.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in the Traditional Plan have access to a separate Retiree Prescription Drug Plan that includes retail pharmacy and mail order service. The plan is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark, and features a three-tiered design. Based on the design adopted at the time the plan was implemented, effective January 1, 2005, copayment amounts for a 30-day supply are set at \$7 for **generic** drugs (Tier I), \$14 for **preferred brand name** drugs (Tier II), and \$29 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are \$7 for **generic** drugs, \$21 for **preferred brand name** drugs, and \$36 for **all other brand name** drugs.

Effective January 1, 2005, there is a \$552 annual maximum in prescription drug copayments per person. Once a person has paid \$552 in copayments, that person is no longer required to pay any prescription drug copayments for the remainder of the calendar year.

Note: The copayment and plan maximum amounts listed above may increase each year based upon a “set cost sharing formula” that is a part of the plan design.

A majority of pharmacies participate with Caremark, however, some do not have agreements with Caremark and are not a part of the Retiree Prescription Drug Plan. When using a non-participating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist and file a claim with Caremark for reimbursement. The reimbursement will be based on the participating pharmacy allowance rather than the actual charge(s) paid.

Some prescription drugs are covered by the Retiree Prescription Drug Plan only in certain quantities.

COORDINATION OF BENEFITS

Almost all group insurance plans, including the Traditional Plan, provide for the coordination of benefits (COB).

Please note: The COB rules may change if Medicare is involved. Please refer to the Medicare section that begins on page 10 for more information.

For group plans that do have a COB provision, the following rules determine which is the primary plan.

- If you, the active employee, are the patient, the Traditional Plan is primary for you. If your spouse or eligible same-sex domestic partner is the patient, and covered under a health plan provided through his or her employer, that plan is the primary plan.
- When Medicare is involved, the benefits of the plan that covers an active employee and/or his or her dependents will be determined before the benefits of a plan that covers a laid-off or a retired employee and his or her dependents.
- If a dependent child is the patient and is covered under both parents' plans, the following birthday rule will apply.

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary plan for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

If two or more plans cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.

- The plan of the parent with custody is primary; followed by
- The plan of the spouse or eligible same-sex domestic partner of the parent with custody of the child; then
- The plan of the parent not having custody of the child.
- If it has been established by a court decree — Qualified Medical Child Support Order (QMCSO) — that one parent has responsibility for the child's health care expenses, then the plan of that parent is primary.
- If none of the above rules determine the order of benefits, the plan that has covered the patient for the longer period is the primary plan.

The Traditional Plan will provide its regular benefits in full when it is the primary plan. As a secondary plan, the Traditional Plan will provide a reduced amount which when added to the benefits paid by the other group plan will equal up to 100 percent of the eligible allowable expense.

Please note: No individual can receive benefits under more than one Traditional Plan contract. There is no coordination of benefits for major medical services for yourself or for any of your dependents if you and your spouse or eligible domestic partner, through separate employment, have selected the SHBP Traditional Plan as your plan.

BASIC BENEFITS

HOSPITALIZATION

Bills for eligible inpatient care provided by a hospital are paid based on the contracted rates or reasonable and customary allowance. If you or a covered family member is admitted to a Horizon BCBSNJ participating hospital in New Jersey, the hospital will electronically transmit the bill to Horizon BCBSNJ. If you enter an out-of-state hospital that has a contract with another local Blue Cross Blue Shield plan, the hospital will send the bill electronically through the Blue Card Program, which will forward it to Horizon BCBSNJ for payment. If you use a non-participating eligible hospital in or outside of New Jersey that does not have a contract with the local Blue Cross Blue Shield plan, you or the hospital should send the bill to Horizon BCBSNJ.

To qualify for benefits under the Traditional Plan, hospital charges must be considered eligible and must be provided in a SHBP eligible facility.

Coverage in the Hospital

The hospital benefits portion of the Traditional Plan covers up to 365 days in a hospital per calendar year. When an individual is hospitalized, (s)he begins working against the 365-day maximum. If (s)he is released from the hospital but is readmitted in the same calendar year, (s)he continues to work against that year's 365-day maximum. At the beginning of the next calendar year, the 365 benefit days renew or start over, **provided that the individual was released from the hospital and has not been readmitted for the same or related conditions for at least 90 days.**

After the 365-day maximum has been reached for a particular person, coverage under hospital benefits stops. Medically-needed hospital expenses can continue to be covered under the Major Medical portion of the plan subject to the total lifetime maximum.

IMPORTANT: If an individual requires extensive, long-term hospitalization, Voluntary Case Management should be considered (see page 46).

Alcohol and Substance Abuse Benefits - Inpatient

Eligible alcohol and substance abuse treatment services are covered like any other general illness under the plan.

Eligible Services and Supplies

The following services and supplies provided during **inpatient** care are eligible under the hospitalization portion of the Traditional Plan when included as part of the hospital bill.

- Bed and meals in a semiprivate room.
- Intensive or special care units when medically needed and at the appropriate level of care.
- Services of all hospital employees including hospital nurses (excluding private duty nursing), interns, residents, physicians assistants, technicians, or independent contractors who are paid by the hospital to provide the services rendered.
- Use of the operating, recovery, treatment, delivery, and/or emergency room.

- Dressings, bandages, oxygen, and plaster casts.
- Drugs and medicines that are administered in the hospital and have been approved by the federal Food and Drug Administration for use by the general public (experimental drugs are not eligible).
- Physical therapy while you are a hospital inpatient.
- Diagnostic X-rays, radioactive isotope studies, and laboratory and pathology services. (If you receive a separate radiology or pathology bill, forward it to Horizon BCBSNJ for consideration under the Major Medical portion of the plan.)
- Services provided by a hospital or nonprofit blood supplier for drawing, processing, or distributing blood.
- Lenses implanted during cataract surgery; in-hospital use of crutches, traction devices and orthopedic devices.
- Surgically implanted cardiac pacemakers, including batteries, electrodes and their replacements.
- All other necessary services and supplies furnished by the hospital except for take-home items and patient convenience items (such as telephone, television, haircuts, guest meals, etc.).

The following facility charges performed in an **outpatient** department and billed by the hospital are eligible under the hospitalization portion of the Traditional Plan (physician charges and other professional fees related to these services may or may not have an Extended Basic Benefit component).

- Accidental injury treatment.
- Alcohol and substance abuse treatment services.
- Application and removal of plaster casts.
- Blood transfusions, paracentesis, and/or thoracentesis.
- Cardiac pacemaker follow-up examinations.
- Chemotherapy, pathology, physical therapy, X-rays (diagnostic), and X-ray therapy.
- Dialysis treatment.
- Poisoning treatment.
- Removal of implanted orthopedic hardware.
- Screening mammograms (limited by age/frequency guidelines - see page 43).
- Surgery of a cutting or cauterizing nature (except for chemical cauterization).
- Approved surgical diagnostic procedures. Call 1-800-414-SHBP (7427) if you need to know if a specific surgical procedure will be covered under this provision.

OTHER SERVICES PAID UNDER BASIC BENEFITS

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, the hospitalization portion of the Traditional Plan pays for care provided in birthing centers under contract to Horizon BCBSNJ. Services routinely provided by the birthing centers, including prenatal, delivery, and postnatal care, will be covered in full under the Basic Benefits portion of the plan, if the delivery takes place at the center. If complications occur during labor and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this care will also be covered in full. If the delivery does not occur at the center, or if the care of the patient transfers to a hospital maternity program, all expenses incurred at the center for prenatal care will be considered under the Major Medical portion of the plan.

Contact Horizon BCBSNJ at 1-800-414-SHBP (7427) to identify eligible birthing centers near you. If you do not reside in New Jersey, call your local Blue Cross Blue Shield plan for eligible birthing centers it has under contract.

Dental Benefits - Inpatient

Dental care under the Traditional Plan is very limited. The Basic Benefits portion of the plan may provide coverage for inpatient and outpatient hospital charges related to any of the services listed below.

- Removal of bony impacted molars.
- The treatment of accidental injuries caused by a traumatic event excluding damage caused by chewing. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person was not enrolled in the plan.
- Treatment for mouth tumors if medically needed and at the appropriate level of care.
- **Medically needed** hospital and anesthesia charges incurred for dental services for severely disabled members and children who can submit convincing documentation for the medical need for the hospitalization/anesthesia services.
Charges for the actual dental procedures would not be eligible for benefit under the Traditional Plan.

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a separate dialysis center, or by an eligible home health agency. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient. Home dialysis will be considered when there is documented evidence that the services cannot be performed in an outpatient facility.

If the dialysis center is not under contract with Horizon BCBSNJ, the charges will be considered under the Major Medical portion of the plan.

Federal Government Hospitals

The Traditional Plan will pay hospitals operated by the United States government (Veterans Administration and Department of Defense) as if they were participating hospitals, regardless of their location, for eligible charges for nonmilitary conditions.

The Traditional Plan will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- Services are for treatment on an emergency basis for accidental injury from an external cause; or
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Home Health Care Agency Benefits

The hospitalization portion of the Traditional Plan covers home health visits as long as the circumstances meet plan guidelines. Members receiving home health care must be home-bound and must require skilled nursing care, physical therapy, occupational therapy, or speech therapy under a plan prescribed by an attending physician and approved by Horizon BCBSNJ. Eligible home health services provided by an approved participating home health agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (R.N.).
- Physical therapy.
- Occupational therapy.
- Speech therapy - see speech therapy plan guidelines on page 45.
- Any other related treatment and services eligible for hospital benefits, except the administration of hemodialysis.
- Medical social services or part-time services by a home health aide during the period when you are receiving eligible skilled nursing care, physical therapy or speech therapy services.

Up to 60 visits are available within 61 days per occurrence. Every three home health care visits by a participating Horizon BCBSNJ home health care agency reduces your available inpatient days by one (1). A prior inpatient hospital stay is not required to qualify for home health agency benefits, however, your provider must contact Horizon BCBSNJ at 1-800-664-BLUE (2583) in order to certify benefits through a participating agency prior to services being rendered. Benefits are not available for services rendered by a non-participating home health care agency.

Home health care services that are deemed "custodial" by Horizon BCBSNJ will not be eligible for benefits under the Traditional Plan. Custodial services are primarily services rendered that do not require the skill level of a nurse for performance. These services include but are not limited to activities of daily living (ADLs): such as bathing, meal preparation, dressing, feeding, aiding in ambulation, cleaning, and laundry functions. Services that are rendered by a nurse or home health aide that have been determined by Horizon BCBSNJ to be maintenance or supportive care are also not eligible for benefits. **Services provided by a companion are not eligible for benefits.**

Home Hemophilia Treatment

Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility.

Hospice Care Benefits

Benefits for hospice care must be provided according to a physician prescribed course of treatment approved by Horizon BCBSNJ with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered.

- Part-time professional nursing services of an R.N. or L.P.N.
- Home health aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician.
- Therapy services (including speech, physical, and occupational therapies).
- Diagnostic services.
- Medical and surgical supplies (with prior authorization) and durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 days of respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the eligible person's terminal condition.
- Dietician services.
- Inpatient room, board, and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits.

- Medical care rendered by the patient's private physician (these services would be paid under Major Medical Benefits).
- Volunteer services.
- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.
- Dialysis treatment.
- Bereavement counseling.

Hospice care benefits are not limited to or counted against the benefit days available under the hospitalization portion of the Traditional Plan. Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call Horizon BCBSNJ at 1-800-664-BLUE (2583).

Mastectomy

Hospital charges related to mastectomy services are covered as follows, unless the patient and physician determine that a shorter stay is medically appropriate:

- A minimum of 72 hours inpatient care following a modified radical mastectomy; or
- A minimum of 48 hours following a simple mastectomy.

Mental Health Benefits - Inpatient

Up to 20 inpatient days for the treatment of non-biologically-based mental, psychoneurotic or personality disorders are covered. These days are renewed every calendar year provided that the patient has not been readmitted to the hospital for at least 90 days for related illnesses.

Once the 20 inpatient benefit days have been exhausted, any additional inpatient days and all in-hospital medical services will be considered under the Major Medical portion of the Traditional plan, subject to the deductible, coinsurance, and annual and lifetime mental health maximum benefits. Please refer to page 43 for more information on available Major Medical Benefits for mental health conditions.

Services rendered for the treatment of a **biologically-based mental illness** are treated like any other illness and are not subject to the 20-day maximum. Biologically-based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Obstetrical Care Benefits - Inpatient

Hospital and delivery charges related to the mother's obstetrical care and the newborn child's and mother's initial stay in the hospital are covered. The plan will provide coverage for a minimum of 48 hours of inpatient care for the mother and newly born child following a vaginal delivery and up to 96 hours following a cesarean section. If a doctor orders care beyond the 48/96 hours, medical records will be required to determine continued medical need.

In some instances, the plan will also pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- The mother must be enrolled as a dependent;
- The mother resides with the member and must be substantially dependent on the member for support and maintenance; and
- The mother is under the age of 23 and unmarried.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if he or she obtains legal custody of the child. The mother may apply for COBRA coverage for the newborn.

Organ Transplants

The following human organ transplant procedures are eligible for coverage only with prior written pre-certification by Horizon BCBSNJ:

- Heart

- Lung
- Heart-lung
- Pancreas
- Liver
- Certain bone marrow transplants.

The following human organ transplant procedures are eligible for coverage without pre-certification by Horizon BCBSNJ:

- Cornea
- Kidney

If your physician has recommended a human organ transplant procedure, call 1-800-414-SHBP (7427) to obtain information on pre-certification.

Services billed by an approved hospital that participates in the Blue Quality Centers for Transplants (BQCT) network for human organ transplant procedures are covered. The plan also provides coverage for the cost of transportation and storage services related to organ only when billed by a BQCT network hospital. Transportation and lodging for the donor or recipient is not eligible.

If you choose to use a hospital that is not participating in the BQCT network, you may be responsible for 20 percent of some charges, in addition to amounts charged by providers that are in excess of the reasonable and customary allowance.

In the absence of other group insurance coverage, charges incurred by the organ donor that are directly related to the transplant will be considered for coverage under this plan.

Benefits are available for surgical services in connection with eligible human organ transplants when provided by and billed by a physician.

Pre-admission Testing

Diagnostic tests that would normally be a part of a hospital stay will also be paid by the plan if they are performed on an outpatient basis by a hospital that participates in the Horizon BCBSNJ pre-admission testing program.

Pre-admission testing is covered at 100 percent only if you are scheduled for admission to a participating hospital for treatment of the diagnosed condition that made the pre-admission test(s) necessary. The testing will also be covered if the admission is postponed or canceled for one of the following reasons:

- The tests show a condition requiring medical treatment before the admission.
- A medical condition develops, delaying the admission.
- A hospital bed is not available on the scheduled date of admission.
- The tests indicate that the admission is not necessary.

Pre-admission testing performed at a nonmember facility is not covered under hospital benefits. It will, however, be covered under the Major Medical portion of the plan.

Private Rooms

If you occupy a private room in a hospital, you must pay the difference between the private room rate and the average semiprivate room rate.

Skilled Nursing Facility

A skilled nursing facility is a specific type of treatment center that falls between a hospital (which provides care for acute illness) and a nursing home (which primarily provides custodial, maintenance, and/or supportive care). *The Traditional Plan does not pay for nursing home care.* Hospitalization coverage does, however, cover *up to 30 days* of care in a skilled nursing facility when it is under a plan prescribed by a doctor and approved by Horizon BCBSNJ. The plan's payment to the member skilled nursing facility will be accepted as payment in full. Room and board charges beyond 30 days are not covered under **Major Medical Benefits**. Any charges, other than room and board charges, not eligible under the hospitalization coverage, will be considered under the Major Medical portion of the plan.

You may be transferred to a member skilled nursing facility directly from your home or from a hospital if your physician prescribes that you need skilled care, therapeutic services, and treatment for your illness or injury.

Surgical Centers/Ophthalmic Surgical Centers

If **surgical procedures** are provided in an eligible **surgical center** instead of a **hospital**, the hospitalization portion of the plan will provide 100 percent coverage for facility charges as long as you are admitted and discharged within a 24-hour period and the center is under contract with any Blue Cross Blue Shield Plan.

The following criteria must be met for the facility fees at any surgical center to be covered.

- The facility must be approved by the Centers for Medicare and Medicaid Services (CMS); and
- The facility charge is separate from the physician's charge.

Ophthalmic Surgical Centers — Facility charges for certain services provided by an outpatient ophthalmic surgical center as an alternative to hospital inpatient or outpatient surgery are covered. Only the following cataract surgical procedures are eligible.

- Extraction of lens with or without iridectomy; intracapsular, with or without enzymes.
- Intracapsular, for dislocated lens.
- Extracapsular.
- Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure).
- Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure).
- Insertion of intraocular lens subsequent to cataract removal (separate procedure).

EXTENDED BASIC BENEFITS

Extended Basic Benefits include a specific set of covered professional services and supplies billed by a doctor that are paid according to a fee schedule on a “first-dollar basis.” This means that the charge, if eligible, is paid according to a fee schedule at 100 percent with no deductible considered. The remaining amount above the level of the fee schedule would then be considered at 80 percent of the reasonable and customary allowance with a deductible under the **Major Medical** portion of the plan.

Eligible Services and Supplies

Specific amounts payable under **Extended Basic Benefits** are shown below:

- Chemotherapy: up to \$500 per calendar year for chemotherapy performed outside a hospital.
- Pathology, laboratory examinations, electroencephalograms, and other clinical tests performed outside a hospital: \$25 per calendar year.
- Physicians' services: a fixed amount for specific surgical and anesthesiological procedures.
- Physical therapy: up to \$50 per calendar year for physical therapy.
- Radioactive isotope studies: up to \$125 per calendar year for radioactive isotope studies wherever performed.
- Radioactive isotope therapy: up to \$500 per calendar year for radioactive isotope therapy wherever performed.
- Radium, radioactive isotope (sealed sources), or radon therapy: \$150 per calendar year for radium, radioactive isotope (sealed sources), or radon therapy.
- Shock therapy: up to a fixed fee schedule amount for electroshock, insulin shock, or similar shock treatments given for mental, psychoneurotic, or personality disorder.
- X-rays (diagnostic): up to \$125 per calendar year for diagnostic X-rays performed, other than inpatient.
- X-ray therapy: up to \$500 per calendar year for X-ray therapy performed, other than inpatient.
- Impacted Teeth: up to \$264 for the removal of bony impacted molars or impacted bicuspid (s) (\$105 for the first tooth and \$53 for each of the next three teeth); Any remaining balance **will not be** considered under the Major Medical portion of the plan.
- Newborn well-care: up to \$42 for care of a healthy newborn child while both mother and child are hospitalized; Any remaining balance **will not be** considered under the Major Medical portion of the plan.

SERVICE BENEFITS

If you are covered in the SHBP Active Group as a full-time employee and meet the income limitations below, the Traditional Plan will pay 100 percent of the doctor's bills for certain basic benefit services, such as surgery, anesthesia, and inpatient medical charges. This provision does not apply to members of the SHBP Retired Group.

- If you are unmarried, with single coverage, you must have a gross annual income of less than \$14,000; or
- If you have member and spouse/domestic partner, parent and child, or family coverage, the combined gross annual income of you and your spouse/domestic partner (if any) must be less than \$20,000.

Gross annual income means salary, wages, business profits, interest, dividends, and income from all sources. In determining if the 100 percent benefit is available, the plan administrator will consider gross annual income in the calendar year before the service was rendered.

In both instances, the 100 percent payment provision is subject to all other plan provisions, such as medical need and reasonable and customary allowances. You are responsible for notifying the plan when you qualify for service benefits within 90 days of the service.

MAJOR MEDICAL BENEFITS

The Traditional Plan includes coverage for Major Medical services provided by doctors and other medical professionals. The provider must meet the SHBP definition of a doctor, hospital, or other approved provider for services to be covered.

Services and Supplies

The following services are included under the **Major Medical** portion of the Traditional Plan.

- Ambulance use for local emergency transport. Transport by invalid coach is not covered.
- Anesthetics and their administration.
- Breast prostheses following reconstructive breast surgery.
- Doctor's services for surgical procedures and for diagnosis and treatment of illness and injury.
- Eligible supplies, including blood and blood plasma, artificial limbs, larynx and eyes, casts, Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age), splints, trusses, braces, crutches, respirator, oxygen and rental of equipment for its use.
- Hospital room and board for a semiprivate room. If you are in a private room, the plan will pay the semiprivate room rate and you must pay the difference. If the hospital has no semiprivate rooms, the Major Medical portion of the plan will pay up to 80 percent of the hospital's lowest private room rate.
- Other supplies and nonprofessional services furnished by the hospital for medical care in the hospital, for example, operating room, X-rays, medicines, laboratory tests, and similar charges.
- Prescription drugs — up to a 90-day supply — dispensed by a licensed pharmacist and approved by the FDA for sale and use in the United States at the dosage and for indications as approved by the FDA (see page 19 for additional information).

Note: *Prescription drug coverage is not available through the Traditional Plan if a separate authorized prescription drug plan, including the SHBP Employee Prescription Drug Plan, is offered through the employer.*

- Private duty professional nursing under very strict standards. Private duty nursing must be ordered by a doctor and provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) other than you, your spouse, or a child, brother, sister, or parent of you or your spouse. Private duty nursing will only be covered under extraordinary circumstances upon evidence of a clear and convincing objective need. Private duty nursing coverage will not be covered if the care is:
 - Custodial care (assistance in the activities of daily living in a home, hospital, or facility of any kind). If private duty nursing care primarily relates to custodial care, regardless of whether there are elements of medically necessary care, the private duty nursing care will not be covered under the Traditional Plan; or

- Normally provided by or should be provided by hospital nursing staff; or
- Rendered by or could be provided by home health aides or any other nurses aides.
- Scalp hair prostheses prescribed or authorized by a doctor, but only if they are furnished in connection with hair loss resulting from:
 - Treatment of disease by radiation or chemicals;
 - Alopecia universalis (totalis); or
 - Alopecia areata.

The maximum amount that will be paid for any one person during a 24-month period is \$500.

- Therapy provided by a qualified speech therapist as described below:
 - Speech therapy to restore speech after a loss or impairment of a demonstrated previous ability to speak. To qualify under (a), the loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. Examples of non-covered therapy include that which is provided to correct pre-speech deficiencies and therapy provided to improve speech skills that have not fully developed.
 - Speech therapy to develop or improve speech after surgery to correct a defect that both (1) existed at birth or (2) impaired, or would have impaired, the ability to speak.
 - Speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).
- Treatment by a licensed physical or occupational therapist. The actual disease must be clinically demonstrated and therapy must be of proven value in the treatment of the condition. An example of physical or occupational therapy not covered is that which is provided for a learning or developmental disability and which is educational in purpose (see page 18) or maintenance care (see page 19).
- Treatment by X-ray, radium, or any other radioactive substance.
- Treatment due to accidental injury to natural teeth and dental prostheses replacing accidentally injured teeth (see *Dental Care* on page 41 for limitations).
- X-rays and lab exams when medically needed and at the appropriate level of care.

MAJOR MEDICAL PAYMENTS

Deductibles

The Major Medical portion of the plan has an annual deductible which means that it is your responsibility to pay the first portion of any eligible medical bills each year.

The deductible amount varies depending on the type of employer for which you work.

State Employees — The deductible amount varies depending on the contract agreement between the labor union that represents you as an employee and the State.

For all non-aligned employees of the State of New Jersey and State colleges and universities; and for State employees and employees of State colleges and universities covered by a collective bargaining agreement that has agreed to provide for higher deductible amounts, the annual deductibles are as follows:

- Single - \$250.
- Member and Spouse or Domestic Partner - \$250 per person.
- Parent and Child(ren) - \$250 for employee and \$250 in aggregate for child(ren).¹
- Family - \$250 for employee and \$250 in aggregate for all other family members.¹

¹The total deductible for dependents adds up to \$250 combined per year.

See your Human Resources Representative to determine your union affiliation.

Local Government/Education Employees, Certain State Employees, and All Retirees —

For employees of a SHBP participating Local Government employer (county, municipality, municipal or local authority, etc.) or Local Board of Education; State employees who are not affected by the contract agreements that provide for higher deductible amounts; and **all** retirees enrolled in the SHBP, the annual deductibles are as follows:

- Single - \$100.
- Member and Spouse or eligible Domestic Partner - \$100 per person.
- Parent and Child(ren) - \$100 for you and \$100 for any one other child.²
- Family - \$100 for you and \$100 for one other family member.²

²If two children each have \$50 in bills, the \$100 deductible for other family members has not been reached. If one child has \$110 in eligible bills, then the \$100 deductible for other family members has been reached and eligible charges for treatment of your spouse or other children would be eligible for payment at 80 percent of the reasonable and customary allowance.

Deductibles — Terms and Conditions

Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your deductibles.

The benefit year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the

year, those eligible charges that were applied toward a deductible may be counted toward meeting the deductible for the following year.

Additionally, if two or more family members are injured in the same accident, then your family must meet only one deductible. For instance, you are a local employee and your house is damaged in a tornado and three of your family members are treated by a physician at a cost of \$50 each in eligible charges, for a total of \$150. The \$100 deductible has been met, and the other \$50 will be considered under the Major Medical portion of the plan.

If you are enrolling in the SHBP for the first time because your employer has decided to join, previously paid charges in the current calendar year can be used to meet the deductible requirements for the Traditional Plan. You must submit documentation to Horizon BCBSNJ showing the eligible charges used to meet the deductible.

For example: You work for a city that is joining the SHBP on July 1. Your employer's prior insurance plan had a deductible of \$200 and you have already paid \$200 for yourself and \$100 for one child. When you join the SHBP on July 1, you will be considered to have met the deductible for yourself and for other family members for that calendar year.

Coinsurance

Under the Major Medical portion of the Traditional Plan, you are required to pay 20 percent of the cost of eligible reasonable and customary charges until you reach your out-of-pocket maximum (the point at which the eligible charges for the year total \$2,000 after deductibles). Once an individual reaches his or her \$2,000 ceiling, the plan will pay 100 percent of the reasonable and customary allowance for treatment that is medically needed. Since the coinsurance applies to each person in your family, the actual amount you are required to pay each year will depend on the number of dependents on your coverage. Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your out-of-pocket maximums.

For example:

Example 1: You have employee only coverage.

- If you are a State employee subject to the plan changes, you pay the first \$250 (the deductible) and 20 percent of the next \$2,000 (or \$400) of eligible charges. After you have spent a total of \$650 (the \$250 deductible and the \$400 in coinsurance), the plan will pay 100 percent of any other eligible charges in that year.
- If you are a local employee, a State employee not subject to plan changes, or a retiree, you pay the first \$100 (the deductible) and 20 percent of the next \$2,000 (or \$400) of eligible charges. After you have spent a total of \$500 (the \$100 deductible and the \$400 in coinsurance), the plan will pay 100 percent of any other eligible charges in that year.

Example 2: You have employee and spouse coverage.

- If you are a State employee subject to the plan changes, you pay the first \$250 for yourself and \$250 for your spouse (the deductibles) and 20 percent of the next \$2,000 in eligible charges for each of you (\$400 apiece or \$800). After you have reached the \$650 limit for each person, the plan will pay 100 percent of

any other eligible charges for each person for the year. The maximum that you might need to pay for deductibles and coinsurance is \$1,300 (\$250 deductible + \$250 deductible + \$400 in coinsurance + \$400 in coinsurance).

- If you are a local employee, a State employee not subject to plan changes, or a retiree, you pay the first \$100 for yourself and \$100 for your spouse (the deductibles) and 20 percent of the next \$2,000 in eligible charges for each of you (\$400 apiece or \$800). After you have reached the \$500 limit for each person, the plan will pay 100 percent of any other eligible charges for each person for the year. The maximum that you might need to pay for deductibles and coinsurance is \$1,000 (\$100 deductible + \$100 deductible + \$400 in coinsurance + \$400 in coinsurance).

Example 3: You have family coverage.

- If you are a State employee subject to the plan changes, you pay the first \$250 for yourself and \$250 for any combination of other family members (the deductibles). After any other family members have over \$250 in combined eligible charges, the deductible for all the other family members has been met and bills for treatment of your spouse and/or other children would be eligible for payment at 80 percent of the reasonable and customary allowance. In addition to the two deductibles, you are responsible for up to \$400 in coinsurance for each person. After each person meets that level, the plan will pay 100 percent of any other eligible charges for each person for the year.
- If you are a local employee, a State employee not subject to plan changes, or a retiree, you pay the first \$100 for yourself and \$100 for any one other family member (the deductibles — must be \$100 for yourself and one other individual. If two children each have \$50.00 in bills, the \$100 for other family members has not been met). After one other family member has over \$100 in eligible charges, the deductible for all the other family members has been met and bills for treatment of your spouse and/or other children would be eligible for payment at 80 percent of the reasonable and customary allowance. In addition to the two deductibles, you are responsible for up to \$400 in coinsurance for each person. After each person meets that level, the plan will pay 100 percent of any other eligible charges for each person for the year.

LIFETIME BENEFIT MAXIMUMS

Major Medical Maximums

The individual lifetime maximum for all benefits paid under the Major Medical portion of the Traditional Plan is **\$1,000,000** subject to an automatic limited restoration feature. Once the maximum lifetime benefit has been paid out, at the start of each calendar year, any previously unused portion of a covered person's maximum will be carried over and **\$2,000** or the lesser amount needed to restore the full maximum will also be made available for benefits for that covered person.

If your coverage under the Traditional Plan ends and begins again at a later date, your individual lifetime maximum benefit resumes at the same level it was when your coverage ended.

Mental Health Maximums

The Traditional Plan also contains a unique automatic restoration provision, which can restore benefits issued for non-biologically-based mental illnesses. This special restoration of benefits is in addition to the restoration provision for the overall plan lifetime benefit maximum. This provision is applicable in the calendar year immediately following the initial calendar year in which benefits are paid for mental illness. The patient must be a covered person at the beginning of the year the restoration begins. The maximum that may be restored in a calendar year is **\$2,000**. The amount restored will be the lesser of **\$2,000** or the amount that will bring the total lifetime benefits to **\$20,000**. A maximum restoration of **\$20,000** is available for the lifetime of the patient. Services for mental and nervous disorders, that are non-biologically-based, have a **\$20,000** lifetime maximum with a **\$2,000** automatic restoration provision for all services.

AUTOMOBILE-RELATED INJURIES

The Traditional Plan will provide secondary coverage to Personal Injury Protection (PIP) unless the plan has been elected as primary coverage by or for the employee covered under this contract. This election is made by the named insured under the auto insurance PIP program and affects that member's family members who are not themselves the named insured under another auto policy. The Traditional Plan may be primary for one member, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Traditional Plan is normally secondary to automobile insurance coverage. However, if the automobile insurance contains provisions which made the automobile insurance coverage secondary or excess to the Traditional Plan, the Traditional Plan will be primary.

If the Traditional Plan is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions and limits set forth in your contract and only for those services normally covered under the Traditional Plan.

Please note: If you elect to have the Traditional Plan as primary to PIP, prior notification to Horizon BCBSNJ is not required. Upon receipt of an auto related claim, Horizon BCBSNJ will request the submission of written documentation, such as a copy of your policy declaration page, for verification of your selection.

If the Traditional Plan is one of several health insurance plans which provide benefits for automobile related injuries and the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

Please note: There is no coordination of benefits for prescription drug expenses.

If the Traditional Plan is secondary to PIP, when applicable, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after PIP has provided coverage, subject to medical appropriateness and other provisions, after application of deductibles and coinsurance; or
- The actual benefits that would have been payable had the Traditional Plan been primary to PIP.

SPECIFIC COVERAGE AREAS

In order to be eligible for reimbursement all services must be medically needed at the appropriate level of care and meet all other plan provisions.

Acupuncture

Acupuncture treatment is covered when the services are for the treatment of pain, documented by a diagnosis, and rendered by a Licensed Acupuncturist or Licensed Medical Doctor (M.D., D.O.). Acupuncture treatment is subject to maintenance and supportive care provisions (see page 19).

Examples of acupuncture services that are not eligible under the Traditional Plan include weight loss and smoking cessation.

Alcohol and Substance Abuse Treatment

Alcohol and substance abuse treatment is covered like any other illness. The following alcohol and substance abuse treatment services are covered when they are provided by an eligible residential treatment facility to a member who is being treated as an inpatient, outpatient, or when they are provided as aftercare by an eligible detoxification facility.

- Counseling for the family of the person who is receiving covered inpatient services, if the family member is covered under the contract.
- Initial evaluation.
- Individual and group therapy.

Psychotherapy to treat alcohol or substance abuse is covered under the mental health benefit and is subject to the annual and lifetime maximum benefits.

Allergy Testing

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical need and appropriateness review before eligibility can be determined. This includes, but is not limited to, the following tests.

- RAST (Radioallergosorbent Testing).
- MAST (Multiple Radioallergosorbent Testing).
- FAST (Fluorescent Allergosorbent Testing).
- ELISA (Enzyme-Linked Immunosorbent Assay).

Ambulance

Ambulance use for local emergency transport to the nearest eligible facility equipped to treat the emergency condition is covered.

The Traditional Plan does not cover chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel, lodging, or communication expenses of patients, practitioners, nurses, or family members.

Biofeedback

Biofeedback to treat a medical illness or a biologically-based mental illness is covered like any other general condition under Major Medical Benefits. Biofeedback to treat non-biologically-based mental or psychiatric conditions will be attributed to mental health and will be subject to the mental health benefit maximums.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. The Traditional Plan does not pay for blood which has been donated or replaced on behalf of the patient.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, Major Medical Benefits will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prosthesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

There is a 30-visit benefit maximum for chiropractic services per person per calendar year. The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing.

Congenital Defects

Surgical procedures necessary to correct congenital birth defects, which significantly impair function, including dental procedures, are covered.

Dental Care

Dental care under the Traditional Plan is very limited. The plan will pay a basic benefit for the removal of bony impacted molars (see *Impacted Teeth* on page 31), and will pay for the treatment of accidental injuries (see below), and treatment for mouth tumors if medically needed and at the appropriate level of care.

Extended Basic Benefits coverage will pay for professional fees for covered dental services, including anesthesia, whether performed in a hospital or a dental office.

There is no additional coverage through Major Medical Benefits toward the removal of bony impacted molars and impacted bicuspid.

Accidental Dental — The Major Medical portion of the Traditional Plan may provide coverage for the treatment of accidental dental injuries. You must have been a covered person at the time the accident occurred. Accidental dental is considered an injury to teeth (must be sound natural

teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

Breaking a tooth while chewing on food is not considered accidental dental. Examples of ineligible dental services include, but are not limited to, breaking a tooth on a popcorn seed, olive pit, or on a bone in a piece of meat.

Stress fractures in teeth are very common and undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement under the Traditional Plan.

The Major Medical portion of the Traditional Plan may also provide coverage for dental prostheses to replace accidentally injured teeth, if the treatment and replacement occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit may be extended.

Diabetic Self-Management Education

Diabetes self-management education is covered when the services are provided by one of the following:

- Physician
- Nurse practitioner
- Clinical nurse specialist
- Registered dietitian certified as a diabetic educator
- Pharmacist
- Podiatrist

Eligible educational services for Traditional Plan members that have been diagnosed with diabetes include:

- One initial diabetic self-management session.
- A maximum of four follow-up refresher sessions per calendar year.

Hospital-Based Weight Loss Programs

Hospital-based weight loss programs may be eligible for benefits for a patient diagnosed with morbid obesity. Call Horizon BCBSNJ at 1-800-414-SHBP (7427) to verify eligibility prior to enrolling in a hospital-based weight loss program.

Infertility Treatment

The State Health Benefits Program has established Assisted Reproductive Technology (ART) benefits that were effective as of July 1, 2000, for members of the Traditional Plan. See *Appendix III* on page 63 for plan details.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. The approved centers in New Jersey are:

- Stone Center at UMDNJ - Newark.
- Midlantic Stone Center - Marlton.

- NJ Kidney Treatment Center - New Brunswick.

Information regarding out-of-state approved lithotripsy centers may be obtained by calling the Horizon BCBSNJ Customer Service at 1-800-414-SHBP (7427).

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, please call Horizon BCBSNJ at 1-800-664-BLUE (2583). The State Health Benefits Program's policy on Lyme Disease treatment is found in *Appendix III* and begins on page 66.

Mammography Benefit

Coverage of screening mammographies is mandated by law and is an exception to the general rule that well care is not covered under the Traditional Plan. Routine mammography is covered as follows:

- One baseline mammography at any age.
- Age 40 and older, one screening mammography per year.
- A woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammography at such age and interval as deemed medically needed and at the appropriate level of care by the woman's health care provider.

Mental Health Treatment

Mental health treatment by any of the following providers working within the scope of their licenses is covered if the treatment is determined to be medically needed and the patient has not reached the annual or lifetime benefit maximums (see page 38 for Mental Health Maximums):

- Licensed psychologist
- Medical doctor
- Licensed clinical social worker (LCSW)
- Certified nurse practitioner (CNP)
- Clinical nurse specialist (CNS)

Services rendered for the treatment of a **biologically-based mental illness** are treated like any other illness and are not subject to plan maximums. Biologically-based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Orthopedic shoes

Orthopedic shoes that are attached to a brace are covered. All other orthopedic shoes are not eligible for reimbursement.

Pain Management

Pain management services are covered subject to Horizon BCBSNJ's guidelines. Pain management therapy must be supported by a comprehensive evaluation of the patient, the rationale for treatment must be well documented, and treatment must include a comprehensive program that is multifaceted and may include education, rest, therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, mental health and behavioral interventions, therapeutic and injection interventions, and surgical interventions, if needed. Treatment will not always achieve complete elimination of a patient's pain. In such cases, an increase in a patient's level of function and teaching the patient strategies to cope with residual pain will be the aim. If treatment reaches a point at which no appreciable improvement in the patient's condition is anticipated, services will be considered maintenance and/or supportive care (see page 19) and will not be eligible for reimbursement.

Pap Smears

Coverage of Annual Pap smears, mandated by law, as ordered by a woman's physician are eligible for coverage, subject to deductible and coinsurance. The office visit, laboratory costs associated with the Pap smear, and any necessary confirmatory tests are covered.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is prescribed by a medical doctor and provided under the guidance of one of the following:

- Doctor
- Anesthesiologist
- Approved home care agency

Physical Therapy

Physical therapy that is medically needed at the appropriate level of care, that is not determined to be maintenance or supportive care, is covered based on one session per day. A session of physical therapy is defined as up to one hour of physical therapy (treatment and/or evaluation) or up to three physical therapy modalities provided on any given day.

Private Duty Nursing

Private duty professional nursing is only available under very strict standards. Private duty nursing will only be covered under extraordinary circumstances upon evidence of a clear and convincing objective need.

Private duty nursing must be ordered by a doctor; and provided by one of the following:

- Registered nurse (R.N.), other than you, your spouse, or a child, brother, sister, or parent of you or your spouse.
- Licensed practical nurse (L.P.N.), other than you, your spouse, or a child, brother, sister, or parent of you or your spouse.

Private duty nursing will not be covered if the care is:

- The type of care normally provided by or that should be provided by hospital nursing staff;

- Rendered by or could be provided by home health aides or any other nurses' aides; or
- Primarily custodial care or assistance in the activities of daily living in a home or facility of any kind.

Scalp Hair Prostheses

A benefit maximum of \$500 in a 24 month period, per person, is covered for scalp hair prostheses prescribed or authorized by a doctor, only if furnished in connection with hair loss resulting from:

- Treatment of disease by radiation or chemicals;
- Alopecia universalis (totalis); or
- Alopecia areata.

Second Surgical Opinion

The Major Medical portion of the Traditional Plan provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedures. The plan will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, the Major Medical portion of the Traditional Plan will provide coverage for one additional consultation if requested by the patient. The plan also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic surgical procedures required by the physicians performing the consultations.

Shock Therapy Benefits

Basic (first-dollar) benefits are payable for charges for electroshock treatments, insulin shock treatments, and other similar treatments given for mental, psychoneurotic, or personality disorder and then Major Medical Benefits apply. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder. There is a limit of 12 shock treatments in each calendar year for each eligible person.

Speech Therapy Benefits

Speech therapy services provided by a qualified speech therapist are covered only as follows.

- Speech therapy services to restore speech after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak. The loss or impairment cannot be caused by a mental, psychoneurotic, or personality disorder.
- Speech therapy to develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak, or would have impaired the ability to speak.

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed is not covered under the Traditional Plan.

In addition, speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Surgical Services

- ***Multiple Procedures***

If multiple procedures are performed during the same operative session, the procedure with the highest Relative Value Unit will be considered the primary procedure and the full reasonable and customary allowance will be allowed for that primary procedure minus any applicable deductible and coinsurance liability. The Relative Value Unit associated with the procedure codes represents the time and skill involved in the performance of the procedure. All additional procedures performed in the same operative session will be secondary procedures paid at 50 percent of the reasonable and customary allowance.

- ***Bilateral Procedures***

Bilateral procedures will be paid at 150 percent of the reasonable and customary allowance for one procedure. Services qualify as bilateral when anatomically there are two specific body parts such as ears, eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a **mouth condition** are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring, or repositioning of teeth and dental implants.

Voluntary Case Management

The State Health Benefits Program provides voluntary case management services to Traditional Plan members. It is often more cost effective and convenient for a case manager to be involved in the coordination of care for a critically/catastrophically ill member in some situations. This service is purely voluntary. You do not have to take advantage of it.

By utilizing the services of a case manager, your medically appropriate care is coordinated and managed to provide the most cost-effective approach for the completion of long-term care goals.

For the patient's family, the primary advantage of case management is the additional flexibility and support provided by the case manager. Sometimes it is possible for the patient to be treated at home or in an alternate setting, such as a rehabilitation center or hospice, with additional services or home health assistance.

Some conditions that typically benefit from the services of a case manager are as follows:

- Severe head injuries.
- Spinal cord injuries.
- Severe burn effecting 20 percent or more of the body area.

- Multiple injuries due to an accident.
- Premature birth.
- Cardiovascular Accident (CVA) or stroke.
- Congenital defect which severely impairs a bodily function.
- Brain injury or defect caused by an accident or other unforeseen incident.
- Terminal illness in which a physician has confirmed a life expectancy of 6 months or less.
- AIDS.

Services that would be considered for case management are identified in various ways.

- Hospital discharge planners contact Horizon BCBSNJ.
- Claim submissions indicate a diagnosis that may benefit from case management services.
- Direct contact by a member or family member inquiring about available case management services.

While the claims administrator may suggest that case management is appropriate for a particular case, the claims administrator is not responsible for initiating case management. Once it has been agreed that the patient can benefit from case management services, the case manager and the patient's physician will plan a course of treatment to provide the most efficient and cost effective quality care possible.

If you would like more information about Voluntary Case Management, please call Horizon BCBSNJ at 1-800-664-BLUE (2583).

CHARGES NOT COVERED BY THE PLAN

Even though a service or supply may not be described or listed in this handbook, that does not make the service or supply eligible for a benefit under this plan.

The following services and supplies are not covered by the Traditional Plan:

- Automobile accident-related injuries or conditions. The Traditional Plan does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
 - Existing motor vehicle insurance contracts;
 - Motor vehicle contracts that were purchased but have since lapsed;
 - Motor vehicle insurance coverage that should have been purchased; and
 - Failure to make timely claims under a motor vehicle insurance policy.
- Autopsy.
- Care that is primarily custodial in nature.
- Chair and stair lifts.
- Charges above the reasonable and customary allowance.
- Charges billed by an Assisted Living Facility.
- Charges for services or supplies not specifically covered under the plan.
- Charges for services rendered by a member of the patient's immediate family (including you, your spouse/domestic partner, your child, brother, sister, or parent of you or your spouse/domestic partner).
- Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.
- Charges incurred prior to or in the course of a legal adoption.
- Charges that should have been paid by Medicare, if Medicare coverage had been in effect.
- Cosmetic procedures — charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in the plan. Among the services that are not covered are:
 - Removal of warts, with the exception of plantar warts;
 - Spider vein treatment; and
 - Plastic surgery when performed primarily to improve the person's appearance.
- Costs involving surrogate motherhood or gestational carriers.
- Court ordered services or treatments.
- Custom-molded shoes, regardless of diagnosis.

- Deluxe models of wheelchairs, prosthetics, and other durable medical equipment.
- Durable medical equipment or supplies which are specifically excluded from coverage. To determine which equipment or supplies are eligible for coverage, call 1-800-414-SHBP (7427).
- Educational or developmental services or supplies, or educational testing. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:
 - Training in the activities of daily living. This does not include training directly related to treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.
 - Instruction in scholastic skills such as reading and writing.
 - Preparation for an occupation.
 - Treatment for learning disabilities.
 - To promote development beyond any level of function previously demonstrated.

In the case of a hospital stay, the length of the stay and hospital services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient.

- Expenses for wilderness rehabilitation programs, diabetic camps, cancer camps, or similar camps or programs.
- Experimental or investigational services or supplies and charges in connection with such services or supplies (see page 17).
- Eye care including:
 - Examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis.
 - Eyeglasses or lenses of any type except initial replacement for loss of the natural lens after cataract surgery.
 - Low vision aids.
 - Eye surgery, such as radial keratotomy, lasik procedures, or other refractive procedures performed for any reason.
- Foot conditions — charges for doctor's services for:
 - A weak, strained, flat, unstable, or imbalanced foot, metatarsalgia or a bunion. However, this exclusion does not apply to an open cutting operation.
 - One or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.
- Government plan charge including a charge for a service or supplies:
 - Furnished by or for the United States government;
 - Furnished by or for any government, unless payment is required by law; or

- To the extent that the service or supply, or any benefit for the charge, is provided by any law or government plan under which the member is or could be covered. This applies to Medicare and "no-fault" medical and dental coverage when required in contracts by a motor vehicle law or similar law.
- Hearing aids.
- Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss.
- Herbal or alternative medicine treatments.
- Hot tubs, saunas, or pools of any type.
- Hypnosis.
- Immunizations and preventive vaccines.
- Legal fees.
- Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
- Marriage counseling.
- Medicare providers — services rendered by providers who are not registered with, or who opt out of, Medicare.
- Modifications to an auto to make it accessible and/or driveable.
- Modifications to a home to make it accessible for a disabled person.
- Mouth conditions — charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 76 of the *Glossary* for the definition of a mouth condition.
- Nursing home care.
- Over-the-counter supplies, supplements, vitamins, medications, or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.
- Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.
- Prescription drug charges or copayments, unless your SHBP participating employer does not provide prescription drug coverage.
- Private rooms in a hospital. If you occupy a private room in a hospital or facility, you must pay the difference between the private room rate and the average semiprivate room rate.
- Preventive care/routine screening services — unless otherwise indicated, the Traditional Plan does not provide coverage for services or supplies that are considered to be performed for any of the following:

- Routine well-care as part of a routine examination.
- Services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered.
- Services that are considered preventive or screening in nature.
- All immunizations/vaccinations — including well-child immunizations/vaccinations.
- Flu shots/pneumonia vaccines.
- Well-care annual physicals.
- Cancer antigen tests that are performed because of a family history. Specific guidelines apply to the eligibility of cancer antigen tests. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
- PSA (Prostate Specific Antigen) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of PSA for non-routine reasons. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
- Self- or home-testing kits whether prescribed by a doctor or not.
- Services or supplies that are not medically needed and/or not at the appropriate level of care and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.
- Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, the plan will not pay if they are usually not billed when there is no coverage available.
- Services and supplies prescribed or provided by an ineligible provider.
- Services rendered before the effective date of coverage or after the termination of coverage date. However, if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through discharge.
- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed (see page 45).
- Sports physicals.
- Supportive care — supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under the Traditional Plan.
- Telephone consultations or provider charges for telephone calls.

- Transport — non-emergency transport via ambulance or transport by coach of any kind (by land, air, or water).
- War — charges for illness or injury due to a current act of war. War means either declared or undeclared, including resistance or armed aggression.
- Work-related injury or disease. This includes the following:
 - Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
 - Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
 - Work-related tests, examinations, or immunizations of any kind required by your work.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the State Health Benefits Program, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services:

Example 1: A physician orders inpatient private duty nursing for a surgery patient. Since private duty nursing is not covered under the plan while confined in a hospital, because these nursing services are provided by the hospital, the charges for private duty nursing will not be paid.

Example 2: A person is studying to become a therapist and is required by the school to enter therapy. The treatment is intended to ensure that the new therapist is well-equipped to work with patients. The treatment is not covered because it is primarily educational.

Example 3: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If the plan determines that the use is so new it is experimental, the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant to be present at certain operations. Other hospitals do not have that requirement. The plan will not pay for the assistant unless it can be demonstrated that the service was medically needed and at the appropriate level of care.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from the Traditional Plan for medical services that are either auto-related or work-related, the Traditional Plan has the right to recover those payments. This means that if your medical expenses are reimbursed through a settlement, satisfied by a judgment, or other means, you are required to return any benefits paid for illness or injury to the Traditional Plan. The repayment will only be equal to the amount paid by the Traditional Plan.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with the Traditional Plan in recovering any amounts payable. The Traditional Plan may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise the Traditional Plan's rights under this provision, before any benefits are provided under your group's policy; or
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which the Traditional Plan may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

WHEN YOU HAVE A CLAIM

FILING A CLAIM

Filing Deadlines - Proof of Loss

Horizon BCBSNJ must be given written proof of a loss for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred**. For example, if a service were incurred in the year 2005, you would have until March 31, 2007, to file the claim.

A claim will not be considered valid unless proof is furnished within the time limit indicated above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Provider's tax identification number;
- Name of patient;
- Date of service;
- Diagnosis;
- Type of service;
- CPT 4 code; and
- Charge for each service.

Foreign Claims

Bills for services that are incurred outside of the United States must include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for reimbursement.

Filling Out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim. The claim mailing address, which is noted on the back of the claim form, is as follows:

**New Jersey State Health Benefits Program
Horizon Blue Cross Blue Shield of New Jersey
PO Box 1609
Newark, New Jersey 07101-1609**

SUBMITTING A CLAIM

Hospital Claims

All New Jersey hospitals file claims directly with Horizon BCBSNJ. Out-of-state hospitals that participate with the local Blue Cross Blue Shield (BCBS) plan will file the claim for you through the Blue Card Program. If you have services out-of-state at a non Blue Card hospital or out of the country, you are responsible for submitting an itemized bill and a completed claim form to Horizon BCBSNJ.

Medical Claims

Providers in the Participating Provider network will file claims directly with Horizon BCBSNJ. Out-of-state providers that participate in the local BCBS plan will file medical claims with Horizon BCBSNJ through the Blue Card Program. Many other providers will also file medical claims as a service to their patients. If they do not, you are responsible for submitting an itemized bill and a completed claim form to Horizon BCBSNJ.

Medicare Claims and Other Coverage

If a member is a New Jersey resident, has Medicare primary coverage, and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to Horizon BCBSNJ.

If a member resides in another state and has Medicare primary coverage, the member will have to submit a copy of the *Medicare Explanation of Benefits*, an itemized bill, and a completed Traditional Plan claim form to Horizon BCBSNJ (see page 12).

If the member has primary coverage with another carrier, the member must include a copy of the *Explanation of Benefits* from the other carrier, an itemized bill, and a completed Traditional Plan claim form to Horizon BCBSNJ.

Out-of-State Claims

Horizon Blue Cross Blue Shield of NJ participates in a program that uses nationwide contracting provider arrangements with all Blue Cross Blue Shield plans. This program allows SHBP participants the use of out-of-state hospitals and doctors. Participants of the SHBP may utilize the services of all hospitals and doctors across the nation who contract with independent Blue Cross Blue Shield Plans.

Authorization to Pay Provider

The medical expense coverage provided by the Traditional Plan is not assignable.

However, the member (or a qualified dependent in case of the member's death) can, with the agreement of Horizon BCBSNJ, request that payment of any benefit for **eligible charges** payable to the member, instead be paid directly to the provider of service or supplies. Once payment is made to the provider at the member's request, Horizon BCBSNJ will not have to pay the benefit again. This direct payment is done as a courtesy to our member and is not an assignment of benefits. In order for benefits to be payable directly to a non-participating provider, the member must authorize this direction of payment by completing the appropriate section of the claim form.

The Providers that participate with any BCBS plan will be paid directly for eligible services.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, medical benefits, or if you need a claim form, call 1-800-414-SHBP (7427).

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the *Claim Appeal Procedures* section (page 61).

APPENDIX I

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP and Horizon BCBSNJ govern this plan. The following schedule of benefits is a summary description of plan benefits. It is not complete and does not describe all the limitations or conditions associated with the coverage as described in prior sections. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in this schedule.

This section lists the types of charges Horizon BCBSNJ will pay for covered services or supplies according to all provisions, including but not limited to medical need and medical appropriateness, the Schedule of Covered Services and Supplies, benefit limitations, and plan exclusions.

Please note: The fact that a doctor may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and/or diagnosis of an illness or injury or make it a covered medical expense.

The plan will provide the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations, and exclusions stated within this booklet.

BASIC (HOSPITALIZATION) BENEFITS

Benefit Period	365 days of inpatient care per Benefit Period. Every two days in a member skilled nursing facility or every three home care visits will count as one benefit day for inpatient care.
Renewal Interval	Benefit Period is renewed when 90 days without care as a related inpatient in a hospital have elapsed.
<u>Covered Services</u>	
Inpatient Hospital Services	100 percent up to 365 days for a semi-private room. Day 366+ subject to deductible and 20 percent coinsurance.
Skilled Nursing Facility Charges	100 percent for up to 30 days.
Ambulatory Surgical Center	100 percent for facility charges.
Home Health Agency Care	100 percent for up to 60 visits within 61 days, per occurrence.

Hospice Care	100 percent.
Accidental Injury	100 percent for facility charges only.
Inpatient Alcohol and Substance Abuse	100 percent , same as general inpatient benefit.
Inpatient Mental or Nervous Conditions	100 percent for up to 20 inpatient days per calendar year. Expenses beyond 20 days are paid under Major Medical Benefits subject to annual and lifetime maximums, deductible, and coinsurance. (For biologically-based mental illnesses, coverage is the same as for any other medical condition.)
Pre-admission Testing	100 percent.
Organ Transplants	100 percent for organ transplants at an approved participating facility. Non-participating facilities are covered at 80 percent subject to deductible and coinsurance. Prior authorization is required except for cornea and kidney transplants.

EXTENDED BASIC (MEDICAL-SURGICAL) BENEFITS

Covered Services

Unless otherwise noted, any balance remaining after payment under Extended Basic Benefits will be paid under the Major Medical portion of the Traditional Plan.

Bony Impacted Molars and Bicuspid	Subject to a \$264 Benefit Period maximum for the removal (\$105 for the first tooth and \$53 for each of the next three teeth) Please note: The remaining charge is the member's responsibility if there is no dental insurance coverage available. It is not eligible for benefit under Major Medical Benefits.
Chemotherapy	Subject to a \$500 Benefit Period maximum.
Newborn Well-Care	Subject to a \$42 Benefit Period maximum while both mother and child are hospitalized. Please note: The remaining charge is the member's responsibility. It is not eligible under Major Medical Benefits.
Pathology	Subject to a \$25 Benefit Period maximum.

Physical Therapy	Subject to a \$50 Benefit Period maximum.
Physician Services for Surgical Procedures . .	Subject to a fixed amount for specific surgical procedures.
Examples:	
Cesarean Section	Subject to a \$651 first dollar benefit per procedure.
Vaginal Delivery	Subject to a \$420 first dollar benefit per procedure.
Total Hysterectomy	Subject to a \$578 first dollar benefit per procedure.
D&C	Subject to a \$126 first dollar benefit per procedure.
Appendectomy	Subject to a \$368 first dollar benefit per procedure.
Repair Inguinal Hernia	Subject to a \$315 first dollar benefit per procedure.
Radioactive Isotope Studies	Subject to a \$125 Benefit Period maximum.
Radioactive Isotope Therapy	Subject to a \$500 Benefit Period maximum.
Radium, Radioactive Isotope (sealed sources) or Radon Therapy	Subject to a \$150 Benefit Period maximum.
Shock Therapy	Subject to a 12 Shock Treatment Benefit Period up to a fixed schedule amount.
X-rays (diagnostic)	Subject to a \$125 Benefit Period maximum.
X-ray Therapy	\$500 Benefit Period maximum for X-ray therapy performed outside a hospital.

MAJOR MEDICAL BENEFITS

Coinsurance	20 percent of reasonable and customary allowance of eligible expense.
Out-of-Pocket Maximum	After \$2,000 in claims for each member, the Traditional Plan pays 100 percent of covered services.

Note: The Out-of-Pocket Maximum cannot be met with:

- Non-covered charges.
- Deductibles.
- Copayments.
- Expenses above the reasonable and customary allowance.

Annual Deductible (see page 35)

State Employees subject to plan changes	\$250 per covered person. \$500 per Member and Spouse/Domestic Partner, Parent and Child, or Family.
Local Employees,	\$100 per covered person.
State Employees <u>not</u> subject to plan changes, and All Retirees	\$200 per Member and Spouse/Domestic Partner, Parent and Child, or Family.

Common Accident Deductible — If two or more covered persons in the same family are injured in the same accident, only one deductible will be applied in a benefit period to the covered services and supplies resulting from the accident.

Fourth Quarter Deductible Carry-over — Covered services and supplies incurred within the last 3 months of a benefit period which were applied against the deductible but did not satisfy the deductible may be carried over and applied against the deductible for the following benefit period.

Prior Carrier Deductible Carry-over — The prior carrier deductible carry-over applies only to new groups joining the SHBP. Charges for covered services and supplies which satisfied any portion of a deductible required for the final benefit period under the employer's prior major medical group contract will be applied to satisfy all or any portion of the initial deductible required under this program.

Major Medical Lifetime Maximum — One million dollars per covered person with an automatic limited restoration feature. At the start of each benefit period, any of the covered person's previously used part of a maximum will then be restored for future charges up to the lesser of (a) \$2,000 or (b) the amount needed to restore the full maximum. If the covered person's coverage ends under the Traditional Plan and begins again at a later date, the lifetime maximum benefit resumes at the same level it was when the coverage ended.

APPENDIX II

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

**Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299**

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the health plan. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is

rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

APPENDIX III

STATE HEALTH BENEFITS PROGRAM MEDICAL TREATMENT POLICIES

INFERTILITY TREATMENT

The following State Health Benefits Program (SHBP) Assisted Reproductive Technology (ART) benefits were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna HMO.

[In Vitro Fertilization (IVF), Embryo Transfer (ET), Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT)]

All services must be provided at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.

Eligible Services

- Consultations with infertility specialists and/or at comprehensive infertility centers are covered. Under the Traditional Plan and NJ PLUS out-of-network, screening tests such as HIV, routine PAP, hepatitis panels, etc., which may be required prior to infertility treatments will not be covered expenses. Under HMO and NJ PLUS in-network, those expenses will be covered.
- Ovulation Induction and Monitoring are covered.
- Laparoscopy, laparotomy, and hysteroscopy for diagnosis or treatment of infertility are covered.
- Attempts to reverse prior sterilizations are covered.
- Infertility treatment is covered if the member had a prior sterilization procedure.
- Up to six attempts at artificial insemination are covered when in concert with ovarian hyperstimulation or when using donor sperm. Artificial insemination is less invasive than other infertility procedures and significantly less expensive and should be attempted when it is likely to succeed.
- The SHBP limits the reimbursement of ART procedures (i.e., IVF¹, ZIFT², GIFT³) and related services to three attempts per successful pregnancy. *An attempt is*

¹IVF is In Vitro Fertilization which is a four step procedure. 1) Eggs produced by administering fertility drugs (gonadotropins) are 2) retrieved from the woman's body and 3) fertilized by sperm in a laboratory dish. The resulting embryos are 4) transferred by catheter to the uterus.

²ZIFT is Zygote Intrafallopian Transfer in which eggs are fertilized by sperm in a laboratory dish and resulting embryos are transferred to the woman's fallopian tubes from which they travel naturally to the uterus.

³GIFT is Gamete Intrafallopian Transfer wherein, following hormonal stimulation of egg production, a mixture of sperm and eggs is transferred, using a minor surgical procedure, to the fallopian tubes, where fertilization may occur.

recorded for IVF or ZIFT when egg harvesting or retrieval and either culture and fertilization of oocyte(s) or intracytoplasmic sperm injection (ICSI) is performed; or, with GIFT, when the gametes are actually transferred to the recipient's fallopian tube. A successful pregnancy is defined as producing a live newborn.

Embryo transfers using frozen embryos do not count as a separate IVF or ZIFT attempt. If the first three attempts are not successful, there is no further IVF, ET, ZIFT or GIFT benefit. This is a lifetime benefit maximum regardless of what plan or how many plans provided the service under the SHBP self-funded plans.

Examples of some of the related services that would be covered within the three attempts include initial consultation, office visits, cost of the drug(s), laboratory and/or radiologic procedures, testicular sperm aspiration (TESA) and percutaneous epididymal sperm aspiration (PESA) and the process of cryopreservation of embryos⁴ although not the storage costs. These procedures would all be subject to the member's deductible and coinsurance or copayment requirements and any lifetime Major Medical Benefit maximum.

- In addition, any necessary ovum or sperm donor costs would be covered, including but not limited to office visits, costs of drugs, laboratory and/or radiologic procedures, retrieval, cryopreservation, etc. but not including costs for transportation, lodging, or any compensation.
- An attempt is recorded based on the criteria as defined regardless of whether fertilization or transfer is successful. This is also true whether or not the pregnancy goes to term, results in a live birth, or if it results in an ectopic pregnancy.
- The number of embryos to be transferred must follow standards set by the American Society of Reproductive Medicine.
- Fetal reductions are covered.
- Blastocyst transfer is covered.
- Assisted hatching techniques are covered, including, but not limited to partial zona dissection, laser zona dissection, zona pellucida, or subzonal drilling.
- Microscopic assessment of oocyte(s), thawing and preparation of cryopreserved embryos, sperm identification from aspiration and preparation for transfer of embryos are covered services.
- The health plan may negotiate global fees for Assisted Reproductive Technology services and procedures with providers. Global fees would include office visits, would remain at the prevailing reimbursement rate (customary charge level), and would be based on an attempt basis. Where global fees cannot be negotiated, reasonable and customary allowances will be paid.
- The process of cryopreservation and sperm banking for a male undergoing cancer treatment who may become infertile as a result are covered. Expenses for storage are not covered.

⁴Cryopreservation is freezing of embryos after a previous ART cycle for later thawing and transferal to the uterus without the need for repeat stimulation and retrieval during subsequent cycles.

Ineligible Services

- Services or procedures that are not eligible for separate or additional reimbursement since they are considered part of another more global service or procedure include, but are not limited to:
 - Medical management fees, cycle management fees, administrative fees, and/or professional management fees billed in addition to office visits.
 - Donor compensation fees.
 - Documentation of fertilization.
 - Mock transfers.
 - Uterine sounding.
- The following services are considered investigational and therefore ineligible for benefit:⁵
 - Acrosome reaction assay - a diagnostic tool that may be used in the evaluation of male infertility or sub-fertility. The acrosome (part of the sperm) is observed under a microscope for "reaction" after being subjected to a stimulus. Based on the reaction, it is proposed that poorly fertilizing sperms can be differentiated from those with good fertilizing capacity.
 - Subzonal insemination (SUZI).
 - Intratubal insemination.
- The following are ineligible for benefit:
 - Ovulation kits or sperm testing kits and supplies.
 - Donor search fees.
 - Cycle management fees or medical management fees.
 - Pre-implantation Genetic Diagnosis (PGD).
 - Storage of frozen embryos or sperm.
 - Costs involving surrogate motherhood are not covered.
 - Under the Traditional Plan and out-of-network in NJ PLUS, screening tests are not covered, including the PAP, HIV, hepatitis panels, etc. which are routinely required prior to IVF. These tests are covered under the HMO plans and in-network NJ PLUS.
 - Psychological evaluation or testing of donor(s).

⁵This list is not all inclusive and does not include all investigational services and procedures. Denials are not limited to those on this list.

LYME DISEASE INTRAVENOUS ANTIBIOTIC THERAPY

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ or the claims will be denied, whether or not the care was medically needed and appropriate to the level of care. When intravenous therapy is pre-certified to be medically needed and appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, please call Horizon BCBSNJ at 1-800-664-BLUE (2583).

Diagnosis

All testing should be initiated by antibody capture immunoassay, enzyme-linked immunosorbent assay (ELISA), or immunofluorescence assay (IFA) as "screening" tests. Because these tests are generally sensitive, specimens negative by ELISA or IFA need not be further tested since the diagnosis of Lyme disease can virtually be excluded. However, specimens that are positive, minimally reactive, or equivocal by ELISA or IFA should be confirmed by Western blots because of their relatively low specificity.⁶ If early Lyme Disease is suspected clinically despite a negative antibody titer, serological investigations (starting with ELISA or IFA) should be repeated approximately 2 to 4 weeks later since 60 percent of infected individuals may test negative at the early stage. Antibiotic therapy may prevent an increase in specific antibodies and seroconversion may even occur after antibiotic therapy.

IgM Western blot is considered positive if two of the following three bands are present: 24 kDa (OspC), 39 kDa (BmpA), and 41 kDa (Fla). IgG Western blot is considered positive if five of the following 10 bands are present: 18 kDa, 21 kDa (OspC), 28 kDa, 30 kDa, 39 kDa, 41 kDa (Fla), 45 kDa, 58 kDa (not GroEl), 66 kDa, and 93 kDa.

Serological findings are dependent on disease duration and clinical manifestation.

Early Localized Lyme Disease (Erythema migrans rash)

- With *early localized Lyme Disease*, less than half of patients have detectable specific antibodies, predominantly IgM. Serologic testing is unnecessary.

Covered Treatment: Early localized Lyme Disease should be treated with oral antibiotic therapy, preferably a 21-day course of doxycycline or amoxicillin, not intravenous therapy. [Patients intolerant to those oral medications may be treated with cefuroxime axetil (oral), clarithromycin (oral), or azithromycin (oral).]⁷ Intravenous therapy is not appropriate unless oral medications are not tolerated. If intravenous antibiotic therapy must be used, 14 days of antibiotic therapy is equivalent to 21 days of oral doxycycline.⁸

⁶In the early stage of the disease (localized or even disseminated), there may be isolated IgM reactivity to ELISA or IFA, or in a minority of patients, there may only be an IgG response. Therefore, both IgM and IgG Western blots are recommended in the early stage.

⁷Note: cefuroxime axetil, clarithromycin, and azithromycin have been studied only in early, localized Lyme Disease, and azithromycin has been shown to be inferior to amoxicillin.

⁸"Ceftriaxone compared with doxycycline for the treatment of acute disseminated Lyme Disease." New England Journal of Medicine 1997. 337:289-94.

Early Disseminated Lyme Disease (Erythema migrans rash with multiple lesions, migratory joint pains and brief arthritis attacks, meningitis, cranial neuritis (usually facial palsy), carditis (usually AV nodal block))

- With early disseminated Lyme Disease, the proportion of detectable specific antibodies rises to 70-90 percent with a switch from IgM to IgG. In order to be considered medically appropriate, the following criteria must be met where applicable:
 - 1) Medical certification of early disseminated disease (disseminated infection with cardiac and neurological problems);
 - 2) Symptomatic pregnant women with failed course of oral antibiotics.

Covered Treatment: Early disseminated disease is treated with oral antibiotics (doxycycline 100 mg. twice a day or amoxicillin 500 mg. three times a day for 21 days).

- Facial palsy with meningitis: doxycycline 200 mg. twice a day or ceftriaxone 2 grams daily for 21 days or, if that is not tolerated, may treat with intravenous antibiotic therapy.
- Intravenous therapy is appropriate for Lyme Carditis or AV block with PR interval greater than 0.3 seconds, for children under the age of nine, or if patient is unable to tolerate oral antibiotics (nausea, vomiting, or malabsorption syndrome).
- Oral antibiotic therapy may be medically appropriate instead of intravenous therapy for palpitations in the absence of EKG changes; "funny feeling on one side of the face" in the absence of facial droop; facial palsy with normal cerebrospinal fluid results.

All intravenous therapy for treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

Pulse therapy, pulse treatment with Imipenem, therapy with Vancomycin, and diagnostic tests involving urine antigen and urine and serum polymerase chain reaction (PCR) are to be considered investigational.

Late/Chronic Disease Lyme Arthritis and Late/Chronic Disease Neuroborreliosis (Persistent infection with prolonged arthritis attacks, chronic encephalomyelitis, chronic axonal polyradiculopathy, acrodermatitis chronica atrophicans)

In order to be considered medically appropriate, the following criteria must be met where applicable:

- Diagnosis based on objective findings including, but not limited to, serologic tests, spinal fluid analysis, neuropsychologic studies, and/or MRI.
- Neuroborreliosis, there is no role for IgM ELISA or Western Blot in late stage disease because the IgM tests have been shown to have a high number of false

positives (low specificity) in patients whose symptoms have been present for more than one month. IgG Western Blot is usually sensitive and specific in this stage. IgG titers are usually high and may remain so for several years, even when treatment is successful. Elevated serum IgG alone indicates previous exposure to *B. burgdorferi* but not necessarily recent or active infection. In no case should serologic reactivity be considered synonymous with active infection.

- Spinal fluid analysis is mandatory in testing for neuroborreliosis unless a patient has a reactive serum test with a confirmatory IgG Western blot and signs of neurologic disease. If a patient has a clinical picture consistent with neuroborreliosis, spinal fluid analysis may be appropriate even in the absence of a positive serologic test. Intravenous antibiotic therapy will not be covered for possible neuroborreliosis in the absence of a reactive serologic test without performing further studies to confirm the diagnosis, i.e., CSF analysis and neuropsychological testing or SPECT scanning.⁹
- Expressing cerebrospinal fluid (CSF) and serum ELISA results as a ratio may help correct for passive diffusion of anti-Borrelia antibodies across the blood brain barrier and can also be used to support (but not confirm) a clinical diagnosis of neuroborreliosis. If the patient has cognitive dysfunction, neuropsychologic studies should be done. If there is peripheral nerve damage, EMG and nerve conduction velocity (NCV) studies are indicated: if there are sensory changes only, somatosensory evoked potentials (SSEP) are in order.

Covered Treatment: may be treated with up to 30 days of intravenous antibiotic therapy.

A second or extended course of intravenous therapy must be pre-certified by Horizon BCBSNJ at its sole discretion prior to extending the course of therapy. There must be sufficient objective evidence, including objective clinical and laboratory findings, of new or extended manifestations of the disease. The plan administrator may require a consultation with an appropriate specialist.

Note: Requests for more than 30 days require clinical/laboratory documentation of the need.

A second course of intravenous therapy is warranted for any one of the following indications:

- Clinical evidence of recurrent or new synovitis if other causes have been ruled out;

⁹Single photon emission computed tomography (SPECT) scanning in and of itself is not suitable to establish the diagnosis of Lyme Disease. It is, however, useful to evaluate regional cerebral blood flow and is to be covered by the plan administrator for patients suspected of Late/Chronic Neuroborreliosis. SPECT scanning has been reported to show at six months that perfusion abnormalities improve in patients with Lyme encephalopathy after a one-month course of intravenous ceftriaxone. Therefore, it may be helpful to demonstrate whether a patient with suspected Lyme Disease actually has encephalopathy and may be helpful to follow response to therapy. SPECT scanning is not required in all patients and should only be used as an adjunct to other diagnostic tests when there is uncertainty as to the patient's diagnosis or response to therapy.

- Clinical evidence of recurrent or new objective neurologic physical findings in the absence of other explanations;
- Laboratory evidence of persistent (non-improving) CSF pleocytosis if other causes have been ruled out (if the spinal fluid showed a marked improvement but not complete resolution of the pleocytosis soon after completing therapy, another course of therapy may not be warranted);
- Laboratory evidence of persistently positive CSF and/or synovial fluid culture, i.e., positive after initial intravenous treatment;
- Laboratory evidence of positive Polymerase Chain Reaction¹⁰ (PCR) in CSF¹¹ and/or synovial fluid - PCR urine or blood tests are not to be considered.

Extended intravenous therapy beyond 30 days as a second course may be approved only if there is:

- Recurrent Lyme arthritis with active synovitis after a 30-day course of appropriate antibiotics (ceftriaxone, cefotaxime, penicillin G); or
- Recurrent neuroborreliosis, documented by CSF pleocytosis, CSF culture, or PCR of CSF¹², or neuropsychological studies.

Examples of cases where an extension or repeat course of intravenous therapy may be medically appropriate include: a patient who had left knee arthritis and received treatment only to develop neurologic disease or arthritis of another joint after termination of treatment; a patient who had treatment of established Lyme Disease in the past and now develops new findings with increasing reactivity with *Borrelia Burgdorferi* as indicated by expansion of the immunologic reactivity with new bands on Western blot.

¹⁰PCR testing of CSF and synovial fluid are to be covered by the plan administrator for patients suspected of Late/Chronic Lyme Disease. Coverage for PCR testing for other uses or fluids will be determined by the plan administrator.

¹¹A persistently positive PCR in spinal fluid should be interpreted with caution. It's not really known what it means. In conjunction with other clinical/laboratory data, it may help support the need for a second course of antibiotics. In and of itself, it would not mandate therapy.

¹²It would be reasonable to extend or repeat treatment if a patient had a persistently positive CSF PCR and ongoing symptoms.

APPENDIX IV

GLOSSARY

Accidental Injury — Physical harm or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member — An employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the SHBP for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue SHBP coverage as a subscriber in the SHBP's COBRA program.

Activities of Daily Living — Day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Allowable Expense — The allowance for charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

Ambulatory Surgical Center — An accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the State Health Benefits Commission may only be filed by a member or the member's legal representative.

Basic Benefits — That portion of the Traditional Plan that provides coverage for eligible hospital (facility) charges. Basic Benefits are paid according to a "first-dollar" basis either in full or at a specific fee schedule. Also known as **hospitalization benefits**.

Benefit Period — The twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically-Based Mental Illness — Diagnosed conditions including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Blue Card Program — A national Blue Cross Blue Shield (BCBS) electronic claims billing program through which participating hospitals and doctors can transmit bills for BCBS plan members to any BCBS-administered health insurance program.

Calendar Year — A year starting January 1 and ending on December 31.

- Case Manager** — A person or entity designated by Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment for those members taking advantage of the Voluntary Case Management Program.
- COBRA** — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.
- Coinsurance** — The portion of an eligible charge which is the member's financial responsibility.
- Coordination of Benefits** — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.
- Cosmetic Services** — Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.
- Covered Person** — An employee, retiree, or COBRA participant or a dependent of an employee, retiree, or COBRA participant who is enrolled in the Traditional Plan.
- Coverage** — The plan design of payment for medical expenses under the program.
- Custodial Care** — Services that do not require the skill level of a nurse to perform. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Custodial care services are not eligible for coverage under the Traditional Plan, including those that are considered to be medically needed.
- Deductible** — The portion of the first eligible charges submitted for payment in each calendar year that the Major Medical portion of the Traditional Plan requires the member or covered dependent to pay.
- Dependent Coverage** — Coverage of an eligible family member of an enrolled member.
- Detoxification Facility** — A health care facility licensed by the state it is in as a detoxification facility for the treatment of alcoholism and/or substance abuse.
- Domestic Partner** — Domestic partner SHBP coverage is only available to State employees/retirees and to Local/Educational employees/retirees whose employer has adopted a resolution to participate in health benefits coverage under Chapter 246, P.L. 2003, the Domestic Partnership Act. Under the Act, a domestic partner is defined for SHBP eligibility as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by registering with the local registrar and receiving a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for more information).

Durable Medical Equipment — Equipment, which is designed and able to withstand repeated use and is customarily used to serve a member with a medical condition.

Eligible Services and Supplies — These are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed and at the appropriate level of treatment for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- Not specifically excluded (listed in the *Charges Not Covered by the Plan* section beginning on page 48).
- Provided while you or your eligible family members were covered by the plan.

Eligible Dependent — A member's spouse or same-sex domestic partner (as defined by Chapter 246, P.L. 2003) and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when (s)he reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued (see page 7).

Emergency — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer — The State, or a local public employer which participates in the State Health Benefits Program.

Extended Basic Benefits — That portion of the Traditional Plan that provides coverage for eligible medical-surgical (professional) charges such as X-rays and lab tests and surgical expenses. Extended Basic Benefits are paid on a "first-dollar" basis according to a specific fee schedule.

Facility Charges — Charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or separate surgical center, dialysis center, or a skilled nursing center. These charges are generally paid under the Basic Benefits (hospitalization) portion of the Traditional Plan.

Family or Medical Leave of Absence — A period of time of pre-determined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for covered services and supplies under your group's program.

First-Dollar Basis — A provision of a benefit plan that provides reimbursement for incurred health care costs "from the first eligible dollar" with no deductible.

Full Medicare Coverage — Enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program.***

Government Hospital — A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county, or city hospital.

Home Health Care Agency — A provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home health care agency.

Hospice — A provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — An approved institution that meets the tests of (1), (2), (3), (4), or (5) below:

- (1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
- (2) It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.
- (3) It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.
- (4) It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:
 - A licensed hospital; or
 - A licensed detoxification facility; or

- A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.
- (5) It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets **all** of the following tests:
- It is equipped and operated mainly to provide an alternative method of childbirth;
 - It is under the direction of a doctor;
 - It allows only doctors to perform surgery;
 - It requires an exam by an obstetrician at least once before delivery;
 - It offers prenatal and postpartum care.
 - It has at least two birthing rooms;
 - It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator;
 - It has the services of registered graduate nurses;
 - It does not allow patients to stay more than 24 hours;
 - It has written agreements with one or more hospitals in the area that meet the tests in (1) or (2) above and will immediately accept patients who develop complications or require post-delivery confinement;
 - It provides for periodic review by an outside agency; and
 - It maintains proper medical records for each patient;

“**Hospital**” does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides home-like or custodial care.

Hospitalization Benefits — Benefits provided under a policy for hospital charges incurred by an insured person because of an illness or injury. Also known as **Basic Benefits**.

Illness — Any disorder of the body or mind of a covered person.

Indemnity Plan — A plan that allows members to choose any eligible provider and hospital for service and receive reimbursement for designated covered services. Payments can be made either to enrollees or directly to health providers. This type of plan is also referred to as fee-for-service. The Traditional Plan is an indemnity plan.

Injury — Damage to the body of a covered person.

Local Employee — For purposes of SHBP coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care — Care given to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function. Maintenance care services, even those that are considered to be medically needed, are not eligible for coverage under the Traditional Plan.

Major Medical Benefits — The supplemental program for health insurance that provides a reimbursement of eligible expenses beyond the **Basic Benefits**. The program normally provides for a deductible and coinsurance formula for specific services (generally involving major illnesses and injuries). Full reimbursement is often provided once the expenses paid by the individual reach a certain level. Although the maximums that limit total benefits are usually substantial, maximums are generally specified and mean that most policies do not provide completely unlimited protection. Limits on particular services, such as psychiatric care, may also be specified.

Medical Need and Appropriate Level of Care — A service or supply that Horizon BCBSNJ determines meets **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.
- That it is the most appropriate level of service or supply considering the potential benefits and harms to the patient.
- It is known to be effective in improving health outcomes (for new interventions, effectiveness is determined by scientific evidence; then,

if necessary, by professional standards; then, if necessary, by expert opinion).

- It is furnished by an eligible provider with appropriate training, experience, staff, and facilities to furnish this particular service or supply.

Medical-Surgical or Professional Benefits — Basic Benefits under the Traditional Plan for professional charges such as X-rays and lab tests and surgical expenses toward the doctor's operating fees. Medical-surgical benefits are paid on a set fee schedule and remaining eligible charges are then automatically considered under the Major Medical portion of the plan. Also known as **Extended Basic Benefits**.

Medicare — The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse who are eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP Retired Group coverage.

Member — An employee, retiree, or dependent who is enrolled under the Traditional Plan.

Mental or Nervous Condition — A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Morbid Obesity — A body mass index (BMI) greater than 40kg/m², **or** a BMI greater than 35kg/m² with associated life-threatening or disabling co-morbidities including, but not limited to, coronary heart disease, diabetes, hypertension, or obstructive sleep apnea.

Mouth Condition — A condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Off-Label Use — A drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Participating Hospital — A health care facility licensed by the State it is in to provide hospital care and services or any U.S. Government-operated hospital which has an agreement with Blue Cross Blue Shield to provide hospital care both to a) the Blue Cross plan's subscribers and b) other Blue Cross plans' subscribers through the Blue Card Program.

Participating Provider — A doctor or hospital which has a written agreement with their local Blue Cross Blue Shield plan to provide care to both that plan's members and other Blue Cross Blue Shield plan members.

Primary Health Plan — A plan which pays benefits for a member's covered charge first, ignoring what the member's secondary plan pays. A secondary health plan then pays the remaining unpaid expenses in accordance with the provisions of the member's secondary health plan.

Provider — Under the SHBP, the term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, and audiometrists who are properly licensed and are working within the scope of their practice.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Reasonable and Customary — The plan makes payments based on the reasonable and customary reasonable and customary allowance for supplies and services in a specific geographic area. The reasonable and customary allowance is the general level of charges made by others in the area for like services or supplies as determined by the Prevailing Healthcare Charges System (PHCS). This schedule is updated on a semi-annual basis. Reasonable and customary allowances are based on actual charges by physicians in a specific geographical area for specific services.

Residential Treatment Facility — A health care facility licensed, certified, or approved by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Retired Group Member — An eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing (s)he has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP.

SHBP Member — An individual who is either a SHBP Active Group, Retired Group, or COBRA participant, and their dependents.

Skilled Nursing Facility — A facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides assistance with daily living.

State Biweekly Employee — For purposes of SHBP coverage, state biweekly employee shall mean a full-time employee of the State, or an appointed or elected officer, paid by

the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

State Health Benefits Commission (Commission) — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of establishing and overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefit Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et.seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State legislature and legislative offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor

- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Substance Abuse — The abuse or addiction to drugs or controlled substances, not including alcohol.

Supportive Care — Care for patients having reached the maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically needed, are not eligible for coverage under the Traditional Plan.

Surgical Center — Also termed as surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — This includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Waiting Period — The period of time between enrollment in the State Health Benefits Program and the date when you become eligible for benefits.

APPENDIX V

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

EFFECTIVE DATE: APRIL 14, 2003.

Protected Health Information

The State Health Benefits Program (SHBP) is required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the SHBP that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the SHBP through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

SHBP Uses and Disclosures of PHI

The SHBP is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the SHBP without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The SHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The SHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The SHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the SHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the SHBP in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: www.state.nj.us/treasury/pensions or by sending an e-mail to: hipaaform@treas.state.nj.us. A member may revoke an authorization at any time.

When using or disclosing PHI, the SHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the SHBP have the following rights regarding their PHI:

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the SHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the SHBP's use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the SHBP amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The SHBP may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the SHBP; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the SHBP or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the SHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Request Confidential Communications: The member has the right to request that the SHBP communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the SHBP to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Questions and Complaints

If you have questions or concerns, please contact the SHBP using the information listed at the end of this Notice.

If members think the SHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the SHBP communicate with them in confi-

dence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The SHBP supports member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP or with the U.S. Department of Health and Human Services.

Contact Office: The State Health Benefits Program—HIPAA Privacy Officer

Address: State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
Bureau of Policy and Planning
PO Box 295
Trenton, NJ 08625-0295

Fax: (609) 341-3410

E-mail: *hipaaform@treas.state.nj.us*

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

ADDRESSES

Our Mailing Address is The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is www.state.nj.us/treasury/pensions/shbp.htm

Our E-mail Address is pensions.nj@treas.state.nj.us

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Benefit Information Library/Fax on Demand (609) 777-1931
Office of Client Services (609) 292-7524
TDD Phone (Hearing Impaired) (609) 292-7718

Horizon Blue Cross Blue Shield of New Jersey 1-800-414-7427 (SHBP)

State Employee Advisory Service (EAS) (609) 292-8543

Rutgers University Personnel Counseling Service (EAP) (732) 932-7539

New Jersey State Police

Employee Advisory Program (EAP) (856) 234-5652
..... (908) 231-1077
..... (609) 633-3718
..... 1-800-FOR-NJSP

University of Medicine and Dentistry of New Jersey (EAP) (973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board 1-800-838-0935
Consumer Assistance for Health Insurance (609) 292-5316
(Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD) .. 1-800-792-9745

New Jersey Department of Health and Senior Services

Division on Senior Affairs 1-800-792-8820
Insurance Counseling 1-800-792-8820
Independent Health Care Appeals Program (609) 633-0660

Centers for Medicare and Medicaid Services 1-800-Medicare

New Jersey Medicare - Part A 1-866-641-2007

New Jersey Medicare - Part B 1-800-462-9306

STATE HEALTH BENEFITS PROGRAM PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Employees and retirees can obtain copies of these publications by contacting their employers or by calling the Division. Our Benefit Information Library (BIL) is available 24 hours-a-day, seven days-a-week. If the items you require have a BIL number, dial (609) 777-1931, from a touch-tone phone, and enter the three-digit BIL selection number when instructed. After the recorded information leave your name, mailing address with ZIP Code, and Social Security number to have the publication or fact sheet mailed to you.

If the items you require have a Fax on Demand (FOD) number, you can have the publication or fact sheet automatically faxed to your fax machine. To use our Fax on Demand service, dial (609) 777-1931. Follow the instructions to access Fax on Demand and, when requested, enter the four-digit FOD selection number along with your fax number (area code and telephone).

Fact sheets and other publications are also available for viewing or downloading over the Internet at: www.state.nj.us/treasury/pensions

General Publications

State Health Benefits Program Summary Program Description booklet

State Health Benefits Program Comparison Summary - Plan comparison chart. (State Employees - FOD #8251; Local Employees - BIL #250, FOD #8130; All Retirees - BIL #130, FOD #8130)

Benefit Information Library Catalog - A catalog of informational items available through the Benefit Information Library and Fax on Demand service. (FOD #8000)

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire*. (BIL #208) (FOD #8208)

Fact Sheet #23, *The State Health Benefits Program and Medicare Parts A & B for Retirees*. (BIL #134) (FOD #8134)

Fact Sheet #25, *Employer Responsibilities under COBRA*. (BIL #345) (FOD #8345)

Fact Sheet #26, *Health Benefits Options upon Termination of Employment*. (BIL #258) (FOD #8258)

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA*. (BIL #254) (FOD #8254)

Fact Sheet #37, *SHBP Employee Dental Plans*. (BIL #256) (FOD #8256)

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS & LEO*. (BIL #136) (FOD #8136)

Fact Sheet #51, *Continuing SHBP Coverage for Overage Children with Disabilities*. (BIL #259) (FOD #8259)

Fact Sheet #60, *Voluntary Furlough Program*. (FOD #8418)

Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*.

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*.

Fact Sheet #71, *Benefits Under the Domestic Partnership Act*. (FOD #8419)

Fact Sheet #73, *Retiree Dental Expense Plan*. (FOD #8257)

SHBP Member Handbooks

SHBP Traditional Plan Member Handbook

SHBP NJ PLUS Member Handbook

SHBP HMO member handbooks are available from the individual HMOs (see *SHBP Summary Program Description* for contact information).

SHBP Employee Prescription Drug Plan Member Handbook

SHBP Employee Dental Plans Member Handbook

SHBP Retiree Dental Expense Plan Member Handbook

